Jan 2010 Orders

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-785-114

ISSUES

¬ Whether Claimant has proven by a preponderance of the evidence that she suffered a compensable injury arising out of and in the course and scope of her employment with Respondent-employer?
¬ If Claimant did prove that she suffered a compensable injury arising out of and in the course and scope of her employment with employer, whether Claimant established by a preponderance of the evidence that the medical benefits she incurred were reasonable and necessary to cure and relieve the effects of the industrial injury?

FINDINGS OF FACT

1. Claimant testified that she began working for employer in February 2008 Claimant's job duties included traveling to different houses and businesses on behalf of employer. Employer is in the business of industrial cleaning. As a part of this business, employer provides clients with emergency on call cleaning if necessary.

2. On December 19, 2008, Claimant arrived at work and was advised by her supervisor that a crew needed to go to Denver for an emergency cleaning project at a Denver hotel. At approximately 9:45 a.m., Employer asked Claimant to be a part of the crew that went to Denver for this assignment and was advised that the assignment would require an overnight stay. Claimant accepted the assignment and was instructed to go home, pack clothes for the trip, and return for a noon departure.

3. There is conflicting evidence as to whether Claimant was asked to drive the van to Denver and whether Claimant was performing work functions at the employer's premises in the time leading up to when she was asked to accept the assignment in Denver. The ALJ finds that Claimant was on the clock from approximately 8:00 a.m. until such time as she was asked to join the crew for the overnight assignment in Denver. The parties agree that Claimant clocked out for her trip home to pack her bags for the trip and Claimant clocked out of work at 9:45 a.m. There is further conflict as to whether Claimant was asked to drive the van on the trip to Denver. The ALJ resolves these conflicts by finding that Claimant was performing work for the employer prior to clocking out to get her overnight bag and by finding that employer intended to have Claimant drive the van on the trip to Denver. However, neither of these findings are outcome determinative in this case.

4. While driving home Claimant was involved in a motor vehicle accident ("MVA") and was taken by ambulance to Vail Valley Medical Center. When Claimant did not appear back at Employer's premises for the scheduled noon departure, Employer began making phone calls to determine Claimant's whereabouts. Employer eventually found a replacement for Claimant on the crew that was going to Denver.

5. Claimant testified that she felt she was obligated to accept the assignment given to her by employer to work the project in Denver. Employer's supervisor, Mr. Monica, testified that the assignment was voluntary, and was offered to Claimant because he believed it was a good opportunity for Claimant to receive overtime. The ALJ credits the testimony of Mr. Monica and finds that Claimant's job was not in jeopardy if she failed to accept this assignment. However, regardless of whether Claimant faced termination if she failed to accept the assignment, the assignment was not voluntary insofar as the employer intended to compensate Claimant for her time spent on the project. Employer also was aware that Claimant, in accepting the assignment, would be required to go home to pack clothing in order for Claimant to complete the assignment.

6. The parties presented conflicting evidence regarding whether Employer was aware of where Claimant lived when she was asked to go home and obtain clothing for her trip. Mr. Monica testified that he believed Claimant lived in Avon at the time he instructed her to go home and fill her overnight bag. Claimant testified that she lived in Gypsum. The ALJ notes that the difference between Gypsum and Avon is approximately thirty (30) miles as is not so significant as to be material to the question of compensability in this case.

7. The ALJ finds that Employer was aware that in accepting the assignment from Employer for the overnight trip in Denver, Claimant would be required to travel home to pack clothing for the overnight trip. The ALJ further finds that because Claimant accepted this assignment, travel was contemplated by the employment contract. The ALJ finds that because the travel occurred during the normal business hours, and after Claimant had clocked in for the day, the mere fact that Claimant clocked out for the purpose of driving home to get her overnight bag does not automatically take the assigned travel out of the employment contract.

8. The ALJ finds that the travel home by the Claimant was at the direction of the employer and conferred a benefit to the employer beyond the employee's arrival at work. In this case, Claimant was already at the assigned departure location for the trip to Denver. However, employer could not assign Claimant to the project due to the fact that Claimant did not have her personal belongings that would be required for an overnight stay. For employer to obtain the benefit of having the Claimant join the crew for the trip to Denver, Claimant was required to return home to obtain her overnight bag. Employer knew Claimant would be required to go home to get her belongings for the overnight stay and in fact requested Claimant do so and return for the noon departure. The ALJ finds that employer was aware that Claimant would not be able to go on the assignment to Denver without retrieving additional clothes from home along with personal belongings. The ALJ finds that this fact scenario is unique to this case insofar as

Claimant was unaware of the overnight assignment until such time as she arrived at work, and there is no credible evidence that Claimant was not proceeding directly from work to pick up her overnight bag pursuant to her employer's instructions at the time of the MVA.

9. The ALJ therefore finds that the travel in this case was contemplated by the employment contract between Claimant and Employer and the injuries resulting from the MVA are therefore compensable under the Colorado Workers' Compensation Act. The ALJ further finds that employer was conferred a benefit beyond Claimant's mere arrival at work as Claimant was already at work when employer requested she leave for the sole purpose of obtaining an overnight bag to allow Claimant to proceed to Denver with the crew of other employees for the Denver assignement.

10. The ALJ credits Claimant's testimony and finds that as a result of the MVA, Claimant was taken by ambulance to Vail Valley Medical Center. The ALJ finds that the medical treatment Claimant incurred at Vail Valley Medical Center as a result of the MVA was reasonable and necessary to cure and relieve the Claimant from the effects of the industrial injury.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

3. In general, claimants injured while going to or coming from work fail to qualify for recovery because such travel is not considered performance of services arising out of and in the course of employment. *Berry's Coffee Shop, Inc. v. Palomba*, 161 Colo. 369, 423 P.2d 2 (1967); *Madden v. Mountain West Fabricators*, 977 P.2d 864 (Colo. 1999). However, a travel status exception applies when the employer requires the Claimant to travel. The essence of the travel status exception is that when the employer requires the Claimant to travel beyond a fixed location established for the performance of his or her duties, the risks of such travel become the risks of employment. *Staff Administrators, Inc. v. Industrial Appeals Claims Office*, 958 P.2d 509 (Colo. App. 1997) *citing Martin K. Eby Construction Co. v. Industrial Commission*, 151 Colo. 320, 377 P.2d 745 (1963).

4. Colorado courts recognize exceptions to this general rule where circumstances create a causal connection between the employment and an injury occurring under special circumstances while an employee is going to or coming from work, such as:

¬ Whether travel occurred during working hours;

¬ Whether travel occurred on or off the employer's premises;

¬ Whether travel was contemplated by the employment contract; and

¬ Whether obligations or conditions of employment created a "zone of special danger" out of which the injury arose.

Madden v. Mountain West Fabricators, *id.* Travel may be contemplated by the employment contract when the employee's travel is at the employer's express or implied request or when such travel confers a benefit on the employer beyond the sole fact of the employee's arrival at work. *See Electric Mutual Liability Insurance Co. v. Industrial Commission,* 154 Colo. 491, 391 P.2d 677 (1964).

5. In addressing the third variable, the *Madden* court determined the travel would be contemplated by the employment contract in the following examples (1) when a particular journey is assigned by the employer; (2) when the employee's travel is at the employer's expense or implied request or when such travel confers a benefit on the employer beyond the sole fact of the employee's arrival at work; or (3) when travel is singled out for special treatment as an inducement to employment. *Madden, supra.*

6. As found, Claimant's travel in this case was at the express request of the employer who requested that Claimant go on an overnight trip to Denver to assist with an assignment in Denver. The ALJ finds that employer was aware of the fact that in accepting the assignment in Denver, Claimant would be required to go home to pack an overnight bag and finds that the travel required for Claimant to be able to take the trip to Denver was at employer's express request. Therefore, the ALJ finds that Claimant's travel home to pack an overnight bag after accepting the assignment in Denver represents travel that was contemplated by the employment contract and at the request of the employer.

7. The ALJ also finds that the travel in this case conferred a benefit to the employer beyond the Claimant's mere arrival at work. Claimant was already at work when employer requested Claimant attend the overnight trip to Denver. Therefore, employer had a benefit beyond Claimant's mere arrival at work, as their employee would have clothes and personal belongings with her that would allow for her to make the overnight trip to Denver. Without Claimant's personal belongings, Claimant could not conceivably make the overnight trip to Denver, and therefore, Claimant's travel to retrieve her personal belongings was necessary to employer having Claimant proceed on the assignment to Denver.

8. The ALJ finds that the remaining criteria for determining if the MVA arose out of and in the course of employment are immaterial in this case in determining whether Claimant's injury is compensable. Nonetheless, the ALJ determines that Claimant's in-

jury that arose during the time period between when she clocked out from work and when she was designated to return to her employer arose during her working hours as Claimant would have otherwise remained at work and on the clock if not instructed by her employer to clock out, go home and get an overnight bag, and return by noon for the overnight trip.

ORDER

It is therefore ordered that:

1. Respondents shall pay for the reasonable medical treatment necessary to cure and relieve Claimant from the effects of her industrial injury as a result of the compensable MVA, including but not limited to the emergency treatment Claimant incurred at Vail Valley Medical Center on the date of her injury.

The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: January 4, 2010

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-746-012

ISSUES

¬ Whether Claimant has proven by a preponderance of the evidence that her claim should be reopened?

¬ If Claimant has shown by a preponderance of the evidence that her claim should be reopened, whether Claimant has proven that the medical treatment she has received is reasonable and necessary to cure and relieve her from the effects of her industrial injury and from an authorized provider?

¬ If Claimant has shown by a preponderance of the evidence that her claim should be reopened, whether Claimant has proven that she is entitled to temporary total disability ("TTD") benefits?

¬ If Claimant has shown by a preponderance of the evidence that her claim should be reopened and she is entitled to TTD benefits, whether Respondents have proven by a preponderance of the evidence that Claimant was responsible for her termination of employment?

¬ The parties stipulated to a base average weekly wage ("AWW") of $516.00. The parties stipulated that Claimant's base AWW could increase based on COBRA benefits, but reserved this issue for future determination, if necessary.

FINDINGS OF FACT

1. Claimant suffered an admitted injury to her back arising out of and in the course of her employment with employer on January 2, 2008 when she was lifting a product in her job as a stocker. Claimant reported the injury to her employer and was referred to Dr. Kinder for medical treatment. Claimant was first examined by Dr. Kinder on January 3, 2008 at which time she reported to Dr. Kinder that she had seen a chiropractor that morning with no relief and was still complaining of severe pain. Dr. Kinder took Claimant off of work until her next evaluation scheduled for January 7, 2008, referred Claimant for chiropractic treatment and provided Claimant with a prescription for a back brace, Naprosyn, Percocet and Flexeril.

2. Claimant returned to Dr. Kinder on January 7, 2008 with continued complaints of significant pain even after 3-4 chiropractic visits. Dr. Kinder noted Claimant was nearly hysterical, crying and refusing to cooperate with the history and examination. Dr. Kinder noted that the examination and the state of patient are not consistent with the described injury. Dr. Kinder released Claimant to return to work with no lifting and continued Claimant's medications. Claimant returned to Dr. Kinder on January 14, 2008 with continued complaints of severe pain. Dr. Kinder noted that Claimant could not pinpoint the exact location of her pain. Claimant was released by Dr. Kinder to return to "full work duty" and advised that no follow up care was necessary. Respondents addressed a letter to Dr. Kinder on January 28, 2008 to which Dr. Kinder responded on February 4, 2008 advising that Claimant reached MMI on January 14, 2008 with no permanent impairment.

3. Claimant also continued to receive treatment with Dr. German, the chiropractor. Dr. German noted Claimant continued to complain of low back pain and muscle spasm. Dr. German last treated Claimant on January 28, 2008 when Claimant reported some tightness in her hips with decreased pain intensity for her low back.

4. Respondents filed a final admission of liability ("FAL") admitting for two days of temporary total disability ("TTD") benefits and no permanent partial disability ("PPD") on February 14, 2008. The FAL did not admit for ongoing medical treatment. Claimant did not object to the FAL and the claim was closed as a matter of law.

5. Claimant testified that she continued to experience low back pain after being discharged from Dr. Kinder and sought treatment with Dr. Thielen. Claimant continued to receive treatment for other maladies, but did not complain of low back pain during these visits. Claimant testified that November 2008, her pain got worse to the point that she could not take it anymore and she reported to the emergency room ("ER") at Memorial Hospital in Craig, Colorado. Claimant reported to the ER that she had low back pain after lifting boxes at employer in January. Claimant reported she was treated by Dr. Kinder, but was not a lot better. Claimant also reported pain down her left leg laterally. Claimant denied any new injury to her back and was provided with prescription medication. Claimant returned to Memorial Hospital on November 30, 2008 with a history of fever and lumbar pain with urinary frequency for the past several days. Claimant also reported a history of chronic low back pain and advised the ER physicians that she had

a prescription for Percocet. Claimant was diagnosed with pyelonephritis and given a prescription for Cipro. Claimant was referred to Dr. Sisk from Memorial Hospital. There was also corroborating testimony at the hearing that the Personnel Manager for employer recommended Dr. Sisk to Claimant when Claimant continued to have problems with her low back complaints.

6. Claimant requested Family Medical Leave Act ("FMLA") benefits for the period of November 29, 2008 through December 9, 2008 noting that she had treated at the emergency room for acute illness and was diagnosed with pyelonephritis. Claimant indicated that her condition had resolved although she may need absence from work for an ultrasound test in the future.

7. Claimant was evaluated by Dr. Thielen on December 9, 2008 with complaints of localized left flank pain. Claimant reported stating to feel the same symptomatology she did a year ago with left lower back and hip discomfort, but reported that the flank pain in different than previous low back pain. Dr. Thielen recommended ruling out an underlying kidney abnormality, but noted that if this was negative, she suspected the pain was likely muscular in origin.

8. Claimant was evaluated by Ms. Bertz in Dr. Sisk's office on December 10, 2008. Claimant reported to Ms. Bertz that her back had been bothering her for the past year, with some temporary help from her chiropractic treatment. Claimant reported tingling and numbness sensations in her left foot and pain in her left thigh. Claimant was diagnosed with a likely disk injury, provided with a Dosepak and referred for physical therapy. Claimant underwent an MRI of the lumbar spine on December 29, 2008 that reveialed a moderate to large left paramedian disk protrusion at L4-5 and a moderate to large left lateral disk protrusion at the L5-S1 level along with mild lower lumber facet arthritis. Claimant returned to the Memorial Hospital ER on December 29, 2008 with continued complaints of low back pain for four weeks with left leg pain. According to the intake form, Claimant had numbness from her left knee to her toes. Claimant related these symptoms to her injury on January 2, 2008.

9. Claimant failed to show for her scheduled shifts with employer on January 3, 4, 6 and 8, 2009. Claimant submitted a handwritten resignation to employer on January 12, 2009. There is conflicting information as to when Claimant resigned her position, as the resignation is dated January 7, 2009, but there is also a date of January 12, 2009 that is scratched out. Based on the testimony presented at the hearing, the ALJ infers that Claimant submitted the resignation letter on January 12, 2009, the same date as her exit interview. Claimant alleges that she called the employer's 800 number to report that she would not be at work on the dates that she missed. The ALJ notes that despite alleging that she properly called in to work on the dates that she missed, Claimant did not document her concerns with regard to the reasons she was terminated during the exit interviews. Claimant testified that portions of the employer records were filled in after she signed the exit interview paper. The ALJ finds Claimant's testimony regarding the circumstances surrounding her termination not credible. The ALJ finds that Claimant failed to properly report her absences to her employer and was responsible for her termination of employment. The ALJ further finds that Claimant voluntarily resigned her position with employer after being advised that she was going to be terminated for job abandonment. The ALJ finds that the employer records were likely not altered after Claimant signed the documentation.

10. Claimant returned to Dr. Thielen on February 18, 2009 with abdominal complaints unrelated to her work injury. Claimant returned to Dr. Sisk on April 20, 2009 with complaints of low back and left lower extremity symptoms. Dr. Sisk reviewed Claimant's MRI scan and noted the MRI revealed moderate to large left sided disc protrusion at L4-5 and L5-S1 with mild lumbar facet arthritis. Dr. Sisk noted that the disk material will probably need to be removed, and referred Claimant to Dr. Fabian for evaluation.

11. Claimant was evaluated by Dr. Fabian on May 5, 2009. Claimant reported to Dr. Fabian that she had not worked since January 2009 because of sever axial pain and left leg pain that she rated as a 9 out of 10. Dr. Fabian noted Claimant's MRI revealed two level degenerative disc disease and herniated disc. Dr. Fabian noted that the degenerative changes were pre-existing, but the herniated disc at the L4-5 level was acute. Dr. Fabian recommended epidural blocks to see if Claimant could get better control of her left lower extremity radiculopathy. Dr. Fabian also noted that surgery would not result in a satisfactory outcome because surgery would not address axial pain. Dr. Fabian took Claimant off of work from all duties until the results of the epidural blocks were completed.

12. The ALJ credits the reports and records from Dr. Kinder and Dr. German noting that Claimant was not complaining of radiating pain immediately after her injury. The ALJ notes that the first report of radiating pain developed almost a year after Claimant's injury. The ALJ finds that the Claimant began complaining of low back pain to the emergency room in November 2008. The ALJ finds that these complaints were related to a possible kidney infection, and were not related to Claimant's January 2008 injury. The ALJ finds Claimant's testimony that she was having severe low back pain when she was placed at MMI by Dr. Kinder unreliable, insofar as Claimant did not contest the February 14, 2008 FAL, nor did Claimant seek medical treatment for her purported back complaints through her private physician until November 2008.

13. Claimant testified that she reported symptoms in her back and down her legs to Dr. Kinder when receiving treatment after her injury. The ALJ finds the testimony of the Claimant regarding her medical treatment not credible. The ALJ notes that Dr. Kinder's medical records regarding Claimant's complaints are supported by the medical records from Dr. German and credits the medical records over Claimant's testimony.

14. The ALJ finds that Claimant has failed to prove that it is more probably true than not that the herniated disk in her low back is related to the work injury of January 2, 2008. While Dr. Fabian noted that the L4-5 disc was acute, the MRI was completed almost a year after the work injury. Moreover, the ALJ credits the medical records from the treating physicians over the testimony of Claimant and finds that the symptoms related to the herniated disk, including the radiating numbness in her left leg were not present until approximately 11 months after the industrial injury.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering

all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., (2007) A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385 (Colo. App. 2000).

3. Section 8-43-303(1), C.R.S., provides:

> At any time within six years after the date of injury, the director or an administrative law judge may … review and reopen any award on the ground of fraud, an overpayment, an error, a mistake, or a change in condition ….

4. Section 8-43-303(1), *supra*, provides that an award may be reopened on the ground of, *inter alia*, change in condition. Claimant shoulders the burden of proving his condition has changed and his entitlement to benefits by a preponderance of the evidence. Section 8-43-201, *supra*; *see Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to change in claimant's physical or mental condition which can be causally connected to the original injury. *Chavez v. Industrial Commission,* 714 p.2d 1328 (Colo. App. 1985). Reopening is appropriate where the degree of permanent disability has changed, or when additional medical or temporary disability benefits are warranted. *Richards v. Industrial Claim Appeals Office*, 996 P.2d 756 (Colo. App. 2000).

5. As found, Claimant has failed to show that it is more likely true than not that her current condition is related to the January 2, 2008 industrial injury. Due to the fact that the Claimant has failed to show that her condition has worsened, Claimant's petition to reopen is denied and dismissed.

ORDER

It is therefore ordered that:

1. Claimant's petition to reopen is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: December 23, 200

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS

STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-751-207

ISSUES

¬ Whether Claimant's proposed artificial disc replacement surgery is reasonable, necessary and related to her industrial injury?

¬ Whether Claimant has shown by a preponderance of the evidence that she is entitled to temporary total disability benefits ("TTD") for the period of June 26, 2009 through June 28, 2009 and from July 13, 2009 through ongoing?

FINDINGS OF FACT

1. Claimant is a 52 year old female who suffered an admitted injury while employed with employer on December 15, 2007 when she slipped and fell on ice and water in the restroom at the employer's premises. As a result of the injury, Claimant complained of pain into her right shoulder and entire arm, in addition to right sided neck pain. Claimant was eventually referred for treatment with Dr. Gebhard in June, 2009. Following an MRI of the cervical spine, Dr. Gebhard diagnosed Claimant with degenerative disc disease with posterior osteophytes at the C5-6 level causing stenosis and bilateral foraminal stenosis at the C5-6 level. Dr. Gebhard therefore recommended a cervical disc replacement surgery for the C5-6 level.

2. Respondents obtained a records review independent medical examination from Dr. Deutsch, an orthopedic surgeon from Hazelwood, Missouri on July 14, 2009. According to Dr. Deutsch, studies have shown recent promising results with the use of a disc prosthesis in the cervical spine, but not the lumbar spine. Dr. Deutsch further noted that whle there is an increasing interest in spinal arthroplasty as an alternative to fusion in conjunction with cervical discectomy, the longevity of this new procedure is unknown. Dr. Deutsch determined that the request for cervical artificial disc replacement at the C5-6 level was not supported by the clinical information. Dr. Deutsch noted that Claimant has not had physical therapy on the neck, nor has she undergone any form of interventional procedures. Dr. Deutsch further noted that the Food and Drug Administration ("FDA") inclusion criteria for utilization of an artificial cervical disk is for patients who have intractable cervical radiculopathy for greater than six months refractory to all conservative treatment.

3. Claimant testified at hearing that she has undergone physical therapy, and the physical therapy did not resolve her neck complaints. The ALJ finds Claimant's testimony credible and consistent with the medical records.

4. Claimant further testified that she missed time from work as a result of her injury, including the period of June 26, June 27 and June 28, 2009. Claimant further testified that she began missing time from work on July 13, 2009 after being taken off or work by Dr. McLaughlin. The ALJ finds the testimony of the Claimant credible and persuasive. The ALJ notes that Dr. McLaughlin's medical records from July 13, 2009 reveal that Claimant was complaining of vomiting for a week, which she felt was related to the medications. Dr. McLaughlin provided Claimant with paperwork for the Family Medical Leave Act ("FMLA"), noting that Claimant may be on restrictions for work. The ALJ fur-

ther finds that Dr. McLaughlin continued Claimant off of work in his July 14, 2009 office note.

5. Claimant was evaluated by Dr. Gebhard on September 9, 2009. Dr. Gebhard noted he had previously recommended a cervical magnetic resonance image ("MRI"), but the MRI was not authorized by Respondents. Dr. Gebhard noted that Claimant continued to complain of significant neck pain that had gotten worse through additional physical therapy.

6. The ALJ finds the reports and opinions from Dr. Gebhard more credible and persuasive than the reports and opinions from Dr. Deutsch. The ALJ finds that, in contrast to Dr. Deutsch's report, Claimant has attempted conservative treatment, including physical therapy, and continues to be symptomatic. The ALJ also notes that Dr. Gebhard's attempts to further investigate Claimant's condition by virtue of an MRI have been frustrated by Respondents refusal to authorize the diagnostic treatment.

7. The ALJ finds that Claimant has shown that it is more probable than not that the cervical artificial disk replacement surgery, recommended by Dr. Gebhard is reasonable and necessary to cure and relieve the effects of the industrial injury. The ALJ rejects Respondents argument that cervical fusion surgery would be a more reasonable treatment for Claimant's condition, and finds that the decision as to what the most reasonable form of treatment for Claimant's cervical condition is best addressed by Dr. Gebhard.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

2. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensa-

ble if it “aggravates accelerates or combines with“ a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

3. The ALJ’s factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness’s testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

4. As found, the ALJ concludes that claimant has shown that it is more probably true than not that her slip and fall injury on December 15, 2007 caused, aggravated or accelerated her need for cervical surgery. The ALJ finds that the proposed artificial disk replacement surgery recommended by Dr. Gebhard is reasonable, necessary and related to her industrial injury.

5. To prove entitlement to temporary total disability (TTD) benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Section 8-42-103(1)(a), *supra*, requires claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that claimant establish physical disability through a medical opinion of an attending physician; claimant's testimony alone may be sufficient to establish a temporary disability. *Lymburn v. Symbios Logic*, 952 P.2d 831 (Colo. App. 1997). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo.App. 1998).

6. As found, Claimant has shown by a preponderance of the evidence that she missed work for the period of June 26 through June 28, 2009 as a result of her industrial injury. Claimant has also shown by a preponderance of the evidence that Dr. McLaughlin took her off of work on July 13, 2009 as a result of her industrial injury. Therefore, the ALJ finds that Claimant has established the right to TTD benefits for the periods of June 26, 2009 through June 28, 2009 and from July 13, 2009 until terminated by rule or statute.

ORDER

It is therefore ordered that:

1. Respondents shall pay for the costs of Claimant's cervical artificial disk replacement surgery pursuant to the Colorado medical fee schedule.
2. Respondents shall pay Claimant temporary disability benefits for the periods of June 26, 2009 through June 28, 2009 and from July 13, 2009 until terminated by law. All matters not determined herein are reserved for future determination.

DATED: December 21, 2009

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-793-831 AND WC 4-762-616

ISSUES

¬ Whether Claimant has proven by a preponderance of the evidence that she sustained a repetitive use occupational disease affecting her hands and left shoulder with an April 28, 2009 date of onset (W.C. No. 4-793-831)?
¬ Whether Claimant has overcome the Division-sponsored Independent Medical Examiner ("DIME") finding that her left shoulder condition is not related to the admitted right shoulder injury of November 7, 2007 (W.C. No. 4-762-616)?
¬ Whether Claimant has proven by a preponderance of the evidence that she is entitled to permanent partial disability ("PPD") benefits based upon a whole person conversion of her upper extremity impairment rating?
¬ Whether Claimant has established an entitlement to an award for disfigurement for her admitted right shoulder injury of November 7, 2007 (W.C. No. 4-762-616)?

FINDINGS OF FACT

1. Claimant sustained an admitted injury to her right shoulder on November 7, 2007 when she attempted to dislodge a large bag of dog food that had become stuck in the checkout conveyor belt. Claimant was referred for medical treatment with St. Mary's Hospital and Medical Center and was evaluated by Dr. Duke on November 12, 2007. Claimant reported to Dr. Duke that she injured her right shoulder while trying to dislodge a bag of dog food and complained of pain along the lateral aspect of her right arm that radiated all the way up into her neck. Claimant was diagnosed with a strain of her right shoulder at the base of the neck and at the superior aspect of her shoulder to the lateral aspect of her arm. Claimant was provided with a prescription for Vicodin and Celebrex and referred for an x-ray of her right arm.
2. Claimant continued to treat with St. Mary's Medical Center and continued to complain of pain in her right shoulder and trapezius and upper back. Claimant was released to return to work with her right arm in a sling. Claimant reported to her treating physician on December 14, 2007 that she no longer had any pain in her upper back and that physical therapy had been helpful. Claimant also reported, however, that she was

still experiencing pain in the deltoid and trapezius muscle region. Claimant was subsequently referred to Dr. Nelson in January 2008. Dr. Nelson diagnosed Claimant with right neck, upper back, shoulder and upper extremity pain consistent with myofascial pain syndrome and referred the Claimant for an electrophysiologic evaluation of the right upper extremity and cervical spine.

3. Claimant underwent an electrophysiologic evaluation on January 16, 2008 that showed mild right carpal tunnel syndrome, but no electrophysiologic evidence to support right mid to lower cervical radiculopathy.

4. Claimant returned to Dr. Stagg on February 5, 2008 with persistent upper extremity pain. Due to Claimant's continued complaints of upper extremity pain, Dr. Stagg ordered a magnetic resonance image ("MRI") of Claimant's elbow that was performed on February 11, 2008, and was essentially unremarkable. Dr. Stagg then recommended an MRI of Claimant's cervical spine that was performed on February 29, 2008 and was likewise unremarkable.

5. Dr. Stagg referred Claimant to Dr. Copeland on March 21, 2008. Dr. Copeland noted Claimant's cervical MRI and elbow MRI were both relatively unremarkable but also noted Claimant had findings on examination and complaints inherent to the shoulder. Dr. Copeland therefore recommended Claimant undergo a shoulder MRI to determine if Claimant had a shoulder tear. Claimant underwent the shoulder MRI on April 8 2008. The shoulder MRI showed supraspinatus tendinopathy with a focal area of partial thickness tearing and a possible small area of full thickness tearing. Based on the results of the MRI, Dr. Copeland recommended Claimant undergo a right shoulder arthroscopy with repair or debridement of the supraspinatus with decompression.

6. Claimant underwent shoulder surgery under the auspices of Dr. Copeland on May 22, 2008. Dr. Copeland performed an arthroscopy of the right shoulder with debridement of the rotator cuff on the articular side with arthroscopic subacromial decompression. The surgery revealed a fraying of the supraspinatus consistent with a partial-thickness rotator cuff tear.

7. Shortly before Claimant's surgery, Dr. Stagg noted that Claimant was beginning to complain of left shoulder pain as a result of having to use it more. Dr. Stagg ordered x-rays of the left shoulder. The x-ray, performed on May 14, 2008, was normal. Claimant continued to follow up with Dr. Copeland and Dr. Stagg following her surgery. During Claimant's follow up treatment, she continued to complain of pain in her cervical region. Dr. Stagg also noted Claimant complaining of pain in her left shoulder on various occasions during her follow up treatment. Additionally, Claimant's physical therapy notes also document Claimant's continued complaints of pain to both her right and left shoulders.

8. Claimant was eventually placed at MMI by Dr. Stagg on February 27, 2009. As of the date of MMI, Claimant continued to complain of pain in both shoulders and cervical pain. Dr. Stagg noted that Claimant felt her left shoulder pain was from stressing that shoulder too much, but also noted that there was no on-the-job injury to her left shoulder. Dr. Stagg recommended Claimant continue with pain management with Dr. Nelson, have 2-3 maintenance visits over the next six months and be provided with a pool pass. Dr. Stagg provided Claimant with a permanent impairment rating of 18% of the upper extremity for her right shoulder injury and 6% whole person for her cervical

injury. These ratings combined for a permanent impairment rating of 16% whole person.

9. Claimant returned to Dr. Stagg on April 28, 2009 with continued complaints of cervical pain and carpal tunnel syndrome. Dr. Stagg noted that Claimant's carpal tunnel syndrome was not part of the original claim when she injured her left shoulder and cervical spine, but might be deemed work-related, but unrelated to the November 7, 2007 injury.

10. Claimant underwent an independent medical examination ("IME") with Dr. Scott on March 5, 2009 at the request of Respondents. Claimant reported to Dr. Scott that she had bilateral pain in her shoulders with the left shoulder hurting more than the right shoulder. Dr. Scott noted that Claimant may have an impingement syndrome of her left shoulder and noted that if Claimant did have an impingement syndrome of the left shoulder, she would not be at MMI for this injury. Claimant also underwent an IME with Dr. Watson on April 27, 2009 at the request of Respondents. Dr. Watson noted that Claimant has complained of numbness and tingling in both hands, but also noted that Claimant had electrodiagnostic testing done that demonstrated a mild median neuropathy on the right wrist without any electrophysiologic changes consistent with a median neuropathy on the left wrist. Dr. Watson also noted that while Claimant had electrodiagnostic changes consistent with median neuropathy/carpal tunnel syndrome, she appeared to become symptomatic after the testing was completed. Dr. Watson noted that both Dr. Stagg and Dr. Scott are of the opinion that the carpal tunnel syndrome is not related to her employment. Dr. Watson, likewise, opined that Claimant's carpal tunnel syndrome was non-occupational related. Dr. Watson also opined that Claimant's left shoulder complaints were not related to her overuse of her left arm following her right shoulder injury.

11. Respondents filed a final admission of liability admitting for the PPD rating from Dr. Stagg and Claimant requested a DIME. Claimant underwent a DIME by Dr. Jacobs on July 6, 2009. In his report, Dr. Jacobs noted Claimant was not a good historian, and noted Claimant could not remember many things; even those one would think are pertinent to her current symptomatology. Dr. Jacobs noted Claimant had a history of right and left shoulder symptoms dating back to 2000. Dr. Jacobs noted Claimant suffered an injury to her right shoulder in November 2008 and eventually underwent an MRI of her right shoulder that showed a rotator cuff tear. Claimant eventually underwent arthroscopic decompression of the right shoulder without arthroplasty or clavicular resection. Dr. Jacobs notes that Claimant eventually developed left shoulder pain that became worse in November 2008 with numbness and tingling in both hands. Dr. Jacobs reviewed Claimant's medical records including the IME reports obtained by Respondents. Dr. Jacobs opined that he concurred with Dr. Watson that Claimant's left shoulder was not related to Claimant's injury, noting that the injury did not involve the left shoulder, and there was not the type of activity for the left shoulder when the right arm was immobilized to create Claimant's symptoms. Dr. Jacobs' physical examination revealed negative Tinel's sign and no Phelan's sign. Dr. Jacobs noted that Claimant's previous IME's all addressed the right shoulder and her physicians provided her with an MMI date of February 27, 2009. Dr. Jacobs was asked to address the left shoulder and found Claimant to be at MMI on July 6, 2009 with a 5% left upper extremity impairment rating, that converted to a 3% whole person impairment rating. However, Dr. Jacobs

also expressed his opinion that Claimant's November 2007 injury did not involve her neck or her left shoulder, nor did it result in the development of Claimant's right or left carpal tunnel syndrome. Dr. Jacobs noted that his impairment rating was only given as a formality as he was asked to address this issue in his examination.

12. Claimant testified at hearing that she still has pain and weakness in her right arm. Claimant also testified she has pain from the top of her arm to the base of her neck. Claimant also testified she had pain in her back and chest. Claimant described her "back" pain as being on her right shoulder between the top of her arm and neck on her upper back. Claimant testified that she can't do house chores or lifting/pushing and can't do activities with her family. Claimant testified that she developed problems with her left arm prior to surgery when her job duties required her to change prices with her left hand. Claimant testified she reported to her employer that she was developing left arm problems and her employer did not fill out an injury report. Claimant testified she developed problems with her bilateral wrists in 2009 approximately 5-6 months after surgery while doing "facing" as a part of her job duties. Claimant testified that facing involved the repetitive use of her upper extremities. Claimant testified that she was eventually moved to the fuel center where he work does not require the repetitive use of her upper extremities. Claimant testified at hearing that she continues to have symptoms in her bilateral wrists and pain in the palm of her hand.

13. As a result of Claimant's shoulder surgery, Claimant has four portal scars on her right shoulder. One portal scar measures ½ inch by ¼ inch. The remaining three (3) portal scars measure ¼ inch by ⅛ inch. The ALJ finds that the scars cause disfigurement that is serious and permanent and normally exposed to public view.

14. The ALJ credits the report from Dr. Jacobs with regard to the cause of Claimant's right shoulder complaints and bilateral carpal tunnel symptoms. The ALJ notes that Claimant developed complaints in her right shoulder before her surgery, and finds that Dr. Jacobs did not find the right shoulder complaints to be a compensable consequence of her November 7, 2007 injury. Claimant has failed to show that it is highly probable and free from substantial doubt that Dr. Jacobs opinion is incorrect.

15. The ALJ also finds that Claimant has failed to show by a preponderance of the evidence that her right shoulder complaints and bilateral carpal tunnel symptoms are the result of a new occupational disease. The ALJ notes that Claimant's bilateral wrist complaints developed 5-6 months after her injury and after her electrodiagnostic testing. The ALJ also finds that Claimant testified that she currently works in the fuel station and her work does not require the repetitive use of the upper extremities, but Claimant's subjective complaints of bilateral wrist pain have not resolved. The ALJ finds that Claimant has failed to show that it is more probably true than not that her wrist complaints are related to her work activities. Likewise, Claimant's left shoulder symptoms developed shortly before Claimant underwent surgery for her right shoulder. Claimant's symptoms did not subside despite being off of work for her right shoulder surgery. The ALJ finds that Claimant's right shoulder impingement is likely not the result of an occupational disease from her employment with employer.

16. The ALJ credits the medical reports from Dr. Stagg and Dr. Nelson and finds that Claimant consistently complained of pain in her shoulder radiating into her neck following her November 7, 2007 industrial injury to her right shoulder. The ALJ finds that the complaints of pain into the neck have been consistently documented by Dr. Stagg. The

ALJ finds that Claimant has shown that it is more probably true than not that she suffered a functional impairment not contained on the schedule of injuries as a result of the November 7, 2007 injury. Claimant's testimony regarding her pain into her cervical region is supported extensively and consistently by the medical records. The ALJ finds that Claimant's pain into the base of her neck limits her ability to rotate her neck as evidenced by Claimant's testimony and the loss of range of motion noted by Dr. Stagg in his February 29, 2009 report. The ALJ finds that the inability to have full range of motion of her neck represents a functional impairment that is not contained on the schedule set forth at Section 8-42-107(2).

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

3. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

4. Sections 8-42-107(8)(b)(III) and (c), C.R.S. provide that the determination of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial doubt, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physi-

cian is incorrect. *Metro Moving and Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage v. Gussert, supra.* A mere difference of opinion between physicians fails to constitute error. *See, e.g., Gonzales v. Browning Ferris Industries of Colorado*, W.C. No. 4-350-356 (Industrial Claim Appeals Office, March 22, 2000).

5. As found, Claimant has failed to show that it is highly probable and free from substantial doubt that the DIME physician was incorrect in his assessment that the left shoulder injury and cervical injury were not related to Claimant's November 7, 2007 injury.

6. As found, Claimant has failed to show that it is more probable than not that her left shoulder injury and bilateral wrist complaints are the result of an occupational disease related to her work at employer. The ALJ notes that Claimant's subjective complaints did not resolve despite not being exposed to the alleged repetitive work duties. The ALJ also notes that Claimant's electrodiagnostic studies were positive prior to Claimant reporting subjective complaints consistent with carpal tunnel syndrome.

7. The question of whether the claimant has sustained an "injury" which is on or off the schedule of impairment depends on whether the claimant has sustained a "functional impairment" to a part of the body that is not contained on the schedule. *Strauch v. PSL Swedish Health Care System*, 917 P.2d 366 (Colo. App. 1996). Functional impairment need not take any particular impairment. Discomfort which interferes with the claimant's ability to use a portion of his body may be considered "impairment." *Mader v. Popejoy Construction Company, Inc.*, W.C. No. 4-198-489, (ICAO August 9, 1996). Pain and discomfort which limits a claimant's ability to use a portion of her body may be considered a "functional impairment" for determining whether an injury is on or off the schedule. *See, e.g., Beck v. Mile Hi Express Inc.*, W.C. No. 4-238-483 (ICAO February 11, 1997).

8. As found, the Claimant has shown that it is more probable than not that she suffered an impairment not contained on the schedule of impairment set forth at Section 8-42-107(2) as a result of the November 7, 2007 injury. While Dr. Jacobs noted that Claimant's November 7, 2007 injury did not result in an injury to the cervical spine, the injury did result in Claimant's consistent subjective complaints of pain into the shoulder and up to the base of her neck. The ALJ finds that this has resulted in pain and discomfort that limits Claimant's ability to use a portion of her body that is off the schedule.

9. Pursuant to Section 8-42-108, C.R.S. 2007, claimant is entitled to a discretionary award up to $4,000 for her serious and permanent bodily disfigurement which is normally exposed to public view. Considering the size, placement, and general appearance of claimant's scarring, the ALJ concludes claimant is entitled to disfigurement benefits in the amount of $600, payable in one lump sum.

ORDER

It is therefore ordered that:

1. Respondents shall pay Claimant permanent partial disability benefits based on an impairment rating of 11% whole person.

2. Respondents shall pay Claimant disfigurement benefits in the amount of $600.
3. Claimant's claim for benefits for the left shoulder and bilateral wrists (W.C. No. 4-793-831) is denied and dismissed.
The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: December 4, 2009

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-775-482

ISSUES

¬ Whether the proposed cervical injections are reasonable medical treatment necessary to cure and relieve the Claimant from the effects of her admitted October 4, 2008 injury?

FINDINGS OF FACT

1. Claimant was employed for employer on October 4, 2008 when she suffered an admitted injury while helping a moving company move a display case. The display case was 6-7 feet tall, four feet long and 2 ½ feet deep and weighed approximately five hundred (500) pounds. As the display case began to fall to the right, Claimant twisted her torso about 45 degrees and stopped the display case from falling further by placing the palms of her hands on the display case. Claimant was worked for employer since 1988 as a retail sales clerk and store manager. Employer is a jewelry store owned by Claimant's father.
2. Claimant testified that as a result of catching the display case, she notice pain in her lower back and her neck. Claimant reported the injury to her employer either on the day it occurred or the next day. Claimant was referred to Dr. Wyman for medical treatment. Claimant was first examined by Dr. Wyman on November 6, 2008, almost one month after the reported injury. Claimant reported to Dr. Wyman with complaints of low back pain related to a reported injury on October 17, 2008 while lifting a display case. Claimant testified that the injury occurred on October 4, 2008, but she did not report it to her employer until October 17, 2008 because she feared for her job. Despite the conflict in the medical records regarding the date of injury, the court interprets Dr. Wyman's medical report to indicate that he was treating Claimant for injuries from her accepted workers' compensation claim. Dr. Wyman noted Claimant developed an acute onset of low back pain after lifting a heavy object. Dr. Wyman's evaluation notes a normal cervical exam.

3. Claimant was referred for a magnetic resonance image ("MRI") of the lumbar spine on November 13, 2008. The MRI revealed a minor saddle shaped disk bulge at the L3-L4 level and a broad based left paracentral foraminal lateral disk protrusion at the L4-L5 level. The MRI also revealed minor degenerative disk disease at the L2-3 and L3-4 levels. Based on the MRI results, Dr. Wyman referred Claimant to Spine Colorado for further treatment.

4. Claimant was evaluated by Dr. Isser at Spine Colorado on December 4, 2008. Claimant reported to Dr. Isser that she suffered an injury on October 4, 2008 when she was moving showcases in a jewelry store and she attempted to catch the showcase after it dropped causing neck pain and low back pain that had been worsening. Dr. Isser reviewed the results of the lumbar MRI and diagnosed Claimant with lumbar degenerative disc disease and cervical radiculopathy. Dr. Isser recommended Claimant undergo a cervical MRI and prescribed Celebrex. Dr. Isser noted that if Claimant did not improve, she would consider injection therapy. Claimant underwent the cervical MRI on December 11, 2008 that revealed degenerative disc bulges/protrusions from the C3-4 level through the C6-7 level with mild thecal sac narrowing without cord contact.

5. Claimant returned to Dr. Isser on December 18, 2008 with continued complaints of aching pain in the neck and parascapular region with one episode of numbness into her upper arm. Dr. Isser opined that Claimant's pain was multifactorial in nature. Dr. Isser recommended Claimant undergo more aggressive physical therapy be evaluated for a home traction unit and, if she did not improve over the next 2-4 weeks, she consider right-sided C4-C5 and C5-C6 facet joint nerve blocks.

6. Respondents sought a records review opinion from Dr. Zuehlsdorff on December 30, 2008. After reviewing the medical records, Dr. Zuehlsdorff noted that on the first two visits with Dr. Wyman he did not see obvious evidence to suggest that the Claimant had a neck injury from the October 4, 2008 injury.

7. Claimant was reevaluated by Dr. Isser on January 23, 2009. Claimant reported to Dr. Isser that he symptoms continued to improve with physical therapy and Claimant denied that she had similar symptoms prior to her injury on October 4, 2008. Based on this information, Dr. Isser reiterated her opinion that Claimant's treatment was related to her October 4, 2008 injury. Claimant returned to Dr. Isser on March 3, 2009. With regard to her neck complaints, Claimant indicated she wished to try cervical facet blocks with steroid. Dr. Isser noted that his these help, but do not last, they would consider radiofrequency lesioning in the future. Claimant returned to Dr. Isser on May 13, 2009 with continued complaints of neck pain on the right side of her neck, radiating occasionally into the right arm, mostly into the neck and parascapular region as well as the low back. Claimant noted she wished to concentrate more on her neck than her low back. Claimant underwent the facet injections on June 3, 2009. Claimant testified she had good relief from the facet injections, and it decreased her pain to a 3 out of 10.

8. Claimant had received prior treatment to her neck as far back as November 1, 1998 when she presented to the emergency room with complaints of a history of muscle spasms in the left side of her neck. Claimant received physical therapy and her condition improved. Claimant again sought treatment for neck pain in October 2002. On October 31, 2003, it was noted Claimant had degenerative disk disease at the C5-6 and C6-7 levels with milder changes at the C4-5 level. Claimant again complained of cervical pain in December 2004 when evaluated by her chiropractor.

9. Claimant was examined by Dr. Treinen on January 15, 2007 when she complained of neck pain at a 9 out of 10. Dr. Treinen noted Claimant's examination revealed decreased range of motion in her neck and provided Claimant with ultrasound and chiropractic manipulation. Claimant continued to receive periodic chiropractic treatment to her neck in June and October 2007.

10. Dr. Raschbacher performed a records review on February 11, 2009 at the request of Respondent-Insurer and noted that Claimant denied similar symptomatology in prior to the injury to Dr. Isser. Dr. Raschbacher noted Claimant had undergone chiropractic care in the past and therefore suggested that liability needed to be established in this case before authorizing further treatment for Claimant's neck injury. Dr. Ogsbury performed an IME of Claimant on April 1, 2009 at the request of Respondent-Insurer. Dr. Ogsbury noted that Claimant denied similar symptoms I the past. After questioning, Claimant noted pain in her legs and went to a chiropractor, Dr. Treinen, for intermittent adjustments between October, 2004 and October, 2007. Claimant complained to Dr. Ogsbury of pain in the neck, right shoulder, right shoulder blade, and right arm generally to the elbow with occasional numbness in the left shoulder, arm and forearm, but not the hand. Dr. Ogsbury diagnosed Claimant with (1) cervical spondylosis; (2) disc protrusion/spur with foraminal narrowing right greater than left at the C6/7 level; (3) right cervical nerve root irritation syndrome; (4) lumbar spondylosis and (5) predominantly axial low back pain syndrome. With regard to Claimant's neck, Dr. Ogsbury opined that Claimant had a cervical radisular syndrome that appeared consistent with the C6-7 level and agreed a xylocain/steroid injection would be appropriate. With regard to causation, Dr. Ogsbury noted that while Claimant reported her neck problems developed at the time of the injury, the frist report of neck problems in the medical records came from Dr. Isser two month after her injury. Claimant reported that she called Dr. Wyman prior to the that time to report a worsening of her cervical problems, but Dr. Ogsbury noted he saw no record of that phone call in the medical records. Based on the lack of medical documentation of Claimant's reported cervical problems, Dr. Ogsbury opined that Claimant's cervical problems were not related to her October 4, 2008 injury.

11. Claimant subsequently provided Dr. Ogsbury with two notes, one from Mr. Williams, her employer, documenting that she complained of neck pain on October 17, 2008 and requested to go home. The second from Dr. Wyman dated April 6, 2009 that indicated the Claimant called on October 30, 2008 requesting to be seen for neck pain. Dr. Ogsbury noted that if these accounts were to be credited, he would opine that Claimant's neck complaints were related to the industrial injury.

12. Dr. Wyman testified at the hearing in this matter on September 29, 2009. Dr. Wyman testified that he had two patient encounters with Claimant, one on November 6, 2008 and one on November 13, 2008. Dr. Wyman testified he did not recall seeing the April 6, 2009 letter, but acknowledged that the letter was generated by his office and given a stamp signature, although Dr. Wyman did not believe he had written the letter. Dr. Wyman testified he was unaware of any conversations with Claimant regarding neck complaints. Dr. Wyman testified he believed the letter was prepared by "Paula" or "Karen" in his office. Dr. Wyman further testified he had no reason to doubt the accuracy of the letter and acknowledged that someone calling in with complaints happens all the time in his practice.

13. The ALJ finds the medical records from Dr. Wyman more credible that the testimony of the Claimant. While Claimant provided a record from Dr. Wyman's office indicating that she called with complaints of neck pain on October 30, 2008, this record was dated April 6, 2009, some six months after the purported complaints to Dr. Wyman's office regarding the neck pain. Moreover, the record with Dr. Wyman's signature was not prepared by Dr. Wyman in this case. Regardless, however, this does not explain why, if Claimant were having such significant complaints of neck pain on October 30, 2008, she did not complain of neck pain when she was evaluated by Dr. Wyman one week later, on November 6, 2008.

14. Claimant testified at the hearing in this matter on August 10, 2009 that she was laid off as of May, 2009. Claimant denied that she was currently working. Respondents presented video surveillance evidence that documented Claimant going to her employer on July 9, 2009, entering the employee only entrance at her employer's place of business and standing behind the cash register counting cash. Respondents presented video surveillance of the Claimant the next day going to her employer's place of business and putting items into a display case. The surveillance later shows claimant taking a cash bag and going to the bank. Claimant testified that she could not recall if she was doing her own personal banking or the banking for her father, her employer. Claimant testified that she was most likely doing her father's banking. The surveillance tape later shows the Claimant back in the store in the late afternoon and then locking the store at 5:09 p.m. Video surveillance of the Claimant at the store performing duties behind the counter was also obtained on July 22, 2009.

15. Claimant admitted that she received and cashed temporary total disability ("TTD") checks covering dates depicted on the video surveillance. Claimant testified that the actions depicted Claimant "volunteering" at the store at her father's request. The ALJ notes, however, that Claimant's "volunteer" work as depicted on the surveillance tape closely depicts work activities that Claimant would be required to perform as an employee. The ALJ also notes that Claimant dresses in a professional fashion, appears at the store around opening time, and is depicted closing and locking the store in the evening. The ALJ finds that the video surveillance contradicts Claimant's testimony that she was laid off as of May 2009 and was not working as of the August 10, 2009 hearing. The ALJ finds the testimony of Claimant not credible.

16. The ALJ notes that the Claimant was at the store at her employer's request performing the duties of her job. The ALJ finds that due to the fact Claimant was collecting TTD benefits during this period of time without the employer advising the insurer of the Claimant's performance of work duties, it calls into question the veracity and motivations of the employer. In that regard, the note from the employer that the Claimant complained of neck pain on October 17, 2008 is deemed not credible.

17. Claimant also provided Respondents answers to interrogatories in this case in which she denied prior neck injuries. When asked on cross-examination with regard to her denial of prior injuries, Claimant explained that she thought the questions pertained to prior work related injuries. Claimant's testimony is again deemed not credible.

18. The ALJ finds the IME report of Dr. Ogsbury dated April 1, 2009 more credible than the reports from Dr. Isser. The ALJ notes that Dr. Isser was relying on a history provided by Claimant of no prior history of similar pain. As such, it does not appear that Claimant reported to Dr. Isser her prior cervical complaints in the years preceding her

alleged October 4, 2008 injury. The ALJ finds that Dr. Isser's opinions are based on an incorrect medical history provided by Claimant. Moreover, insofar as Dr. Ogsbury qualified his opinion later after receiving notes purportedly documenting Claimant's neck complaints in October 2008, the ALJ finds that these notes are unreliable as one came from Claimant's father who subsequently benefited from Claimant volunteering at the shop while receiving TTD benefits and the second represented a signed physician's note that was not signed by the physician in question. Despite Dr. Wyman's testimony that he had no reason to question the accuracy of the note bearing his signature, Dr. Wyman did not make the note in question. Claimant did not present the testimony of the employee at Dr. Wyman's office to whom she spoke on October 30, 2008 to establish the veracity of the April 6, 2009 note. More importantly, as noted earlier, even if Claimant did contact Dr. Wyman's office on October 30, 2008 complaining of neck pain so severe that she was unable to work on October 17, 2008, it does not explain the lack of any complaints of neck issues when she was examined by Dr. Wyman one week later.

19. The ALJ finds that Claimant did not complain of cervical complaints until her examination with Dr. Isser in December, 2008. The ALJ finds Claimant's testimony that she experienced neck pain following the October 4, 2008 incident, but did not report it to her employer until October 17, 2008 because she feared for her job not credible in light of the fact that her father is her employer, and assisted Claimant in pursuing this claim by drafting the note to Dr. Ogsbury.

20. The ALJ finds that Claimant has failed to prove that it is more likely true than not that the proposed cervical injections are reasonable and necessary to cure and relieve the Claimant from the effects of the October 4, 2008 industrial injury.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S., 2006. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

2. A compensable industrial accident is one that results in an injury requiring medical treatment or causing disability. The existence of a preexisting medical condition does not preclude the employee from suffering a compensable injury where the industrial aggravation is the proximate cause of the disability or need for treatment. *See H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990); *see also Subsequent Injury Fund v. Thompson*, 793 P.2d 576 (Colo. App. 1990). A work related injury is compensable if it "aggravates accelerates or combines with" a preexisting disease or infirmity to produce disability or need for treatment. *See H & H Warehouse v. Vicory, supra.*

3. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000). When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and action; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2006).

4. As found, the ALJ credits the testimony of Dr. Ogsbury over the report from Dr. Isser and finds that Claimant has failed to show that it is more probable than not that cervical injections are reasonable, necessary and related medical treatment designed to cure and relieve Claimant from the effects of the October 4, 2008 industrial injury.

ORDER

It is therefore ordered that:

1. Claimant's claim for cervical injections is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: December 18, 2009

Keith E. Mottram
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-801-831

ISSUES

Issues for determination include compensability, average weekly wage, temporary total disability benefits, medical benefits, and a reduction in compensation based on the employer's failure to insure for workers' compensation.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ enters the following findings of fact:

1. The claimant appeared personally and through counsel. The employer appeared by telephone through its owner. At the commencement of the hearing claimant's coun-

sel announced that the parties had reached a stipulation resolving the issues for hearing. The parties agreed to read the stipulations into the record and have them entered as an order of the court. The parties stipulated as follows.

2. The claimant suffered a compensable injury while employed by Sid Martindale at the employer on September 3, 2008.

3. The claimant incurred injuries in the September 3, 2008 accident which included a fracture of his right hip, a laceration to his pelvis, and a right wrist injury.

4. The claimant's average weekly wage was $560. The claimant earned $14 per hour and was employed at 40 hours per week.

5. The claimant suffered the injury within the course and scope of his employment when a clip, which was being used to lift steel metal by a crane, slipped and struck the claimant forcefully causing the injuries set forth above.

6. The employer called for emergency treatment at the accident scene, and Weld County paramedics responded and provided treatment to the claimant. The claimant was transported to North Colorado Medical Center.

7. Treatment was provided at North Colorado Medical Center that included x-rays, imaging studies, and evaluation.

8. Emergency room physicians, after providing care, referred to the claimant to Scott Dhupar, M.D., an orthopedic surgeon.

9. The claimant received follow-up care from Dr. Dhupar until being released on October 29, 2008.

10. The medical treatment provided by Weld County Paramedics, North Colorado Medical Center, Scott Dhupar, M.D., Banner Imaging Associates, and their referrals, is reasonable and necessary, and directly related to the injury of September 3, 2008.

11. The employer is responsible for all of the medical bills incurred by the claimant as the result of the September 3, 2008 injury.

12. A bill in the amount of $29 to Banner Imaging Associates is still outstanding and is the responsibility of the employer.

13. The remaining outstanding medical bills as related to the September 3, 2008 accident have been paid.

14. The claimant paid nine $200 payments to Professional Finance Company for bills related to the September 3, 2008 incident.

15. The employer paid off the medical bills on December 15, 2009.

16. The employer is responsible to repay the claimant for the nine $200 payments made to Professional Finance Company in the total amount of $1,800.

17. The claimant, as the direct result of his injury, was temporarily and totally disabled from September 3, 2008 to October 16, 2008 pursuant to *C.R.S.*, §8-42-105(1). Temporary total disability benefits are owed to the claimant by the employer for that period.

18. At the time of the claimant's injury, the employer was not insured for workers' compensation purposes.

19. Temporary total disability benefits are awarded to the claimant from September 3, 2008 to October 16, 2008 in the gross amount of $3,520, said amount being inclusive of the penalty, for failure to be insured pursuant to *C.R.S.*, §8-43-408(1).

20. The temporary total disability benefits remain unpaid to the claimant at this time.

21. The claimant agrees to stay collection and execution proceeding of this Order for 90 days from December 18, 2009.

CONCLUSIONS OF LAW

The ALJ concludes that the parties' stipulations, as fully ser forth above, are approved and made an order of the court.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the ALJ enters the following order:

1. The employer shall pay the outstanding bill in the amount of $29 to Banner Imaging Associates.

2. The employer shall pay to the claimant the sum of $1,800 to reimburse the claimant for medical bills previously paid.

3. The employer shall pay to the claimant the sum of $3,520 for temporary disability benefits owed from September 3, 2008 to October 16, 2008.

4. The amounts owed, if paid, to the claimant should be through his attorney, Michael D. Mullison, and in certified funds or money order.

5. The employer shall pay Claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

6. Issues not explicitly determined herein are reserved for future determination by the parties.

7. In lieu of payment in the above compensation for benefits to the claimant, the employer shall, within 90 days of the date of December 18, 2009:

   a. deposit the sum of $5,349 ($1,800 plus $3,520 plus $29) with the Division of Workers' Compensation, as Trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to the Division of Workers' Compensation/Trustee. The check shall be mailed to the Division of Workers' Compensation, P. O. Box 300009, Denver, CO 80203-0009, Attn: Sue Sobolik/ Trustee; or

   b. file a bond in the sum of $5,349 with the Division of Workers' Compensation: 1) signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation;

or 2) issued by a surety company authorized to do business in Colorado.

The above designated sum to the Trustee or bond shall guarantee payment of the compensation and benefits awarded.

8. Employer shall notify the Division of Workers' Compensation regarding payments made pursuant to this Order at: Sue Sobolik, Division of Workers' Compensation, Subsequent Injury Fund, P. O. Box 300009, Denver, CO 80203-0009.

9 Issues not resolved by this order are reserved for future determination.

DATED: January 4, 2010

David P. Cain
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-699-837 & WC 4-741-385

ISSUES

The issues determined herein are compensability of an occupational disease in WC 4-741-385, appeal of the orders of a Prehearing Administrative Law Judge ("PALJ"), and attorney fees.

FINDINGS OF FACT

1. Claimant is 42 years old and is left-hand dominant. She has worked for 10 years as a telephone operator and clerk for the employer. She answered the telephone by using her right hand on a ten-key pad on a computer keyboard to her left. She typed short messages into that computer keyboard. She used her right thumb on the 10-key numbers. Claimant also operated a second computer and keyboard to her right. She input work orders, cash sales, invoices, and other data. She filed paper documents. She used a manual stapler to staple documents. On occasion, she used the stapler 100 to 200 times per day. She folded statements, stuffed them, and sealed the envelopes for about 6 hours on one day near the beginning of each month.

2. Claimant has no outside hobbies. She has used her hands outside work only for activities of daily living.

3. On May 19, 2006, claimant sustained an admitted industrial injury to her right upper extremity when she used a manual stapler repetitively, pressing hard to staple hundreds of packets of papers. She developed pain at the base of her right thumb and ra-

dial aspect of her wrist. In W.C. No. 4-699-837 the insurer filed a General Admission of Liability ("GAL") dated October 3, 2006.

4. On November 7, 2007, claimant filed a Workers' Claim for Compensation in W.C. No. 4-741-385 alleging an industrial injury to her left arm with a date of injury of October 24, 2007. Claimant alleged that the injury was due to overuse of her left arm due to her inability to adequately use the right arm because of the work injury to the right hand. Respondents filed a Notice of Contest on November 28, 2007, indicating that this injury was not work related.

5. On December 7, 2007, Dr. Rook examined claimant. Dr. Rook concluded that, because of the right upper extremity problem, the patient had to overuse her left upper extremity and the result was the gradual development of left hand pain, which progressively worsened. Dr. Rook noted that claimant was left hand dominant, but she was not having any left hand pain when she injured her right hand. Claimant denied any acute traumas to her left upper extremity. Dr. Rook opined that it was the overuse of the left upper extremity that lead to the development of the left upper extremity pain problems. Dr. Rook indicated that claimant's current work activities were not repetitive in nature and since sustaining her right upper extremity injury she had not had to perform significant lifting or forceful gripping in her activities at work. Rather it was the heavy reliance upon the left upper extremity to compensate for the injured right upper extremity that lead to the left upper extremity condition. Dr. Rook opined that, if not for the right upper extremity occupational injury, claimant would not have developed the left upper extremity condition. Therefore, he felt that the left upper extremity condition was related to her original occupational injury.

6. After hearing, the Judge issued an order on April 3, 2008, finding respondents liable for the right thumb carpalmetacarpal surgery due to the original occupational injury in WC 4-699-837. Claimant subsequently underwent the surgery.

7. On April 9, 2008, claimant's attorney wrote to respondents' attorney that claimant had difficulty with her left upper extremity as an apparent result of the overuse injury to her right upper extremity and she demanded authorization for claimant immediately to see Dr. Dern and Dr. Rook for evaluation and treatment as necessary for her left upper extremity compensatory injury.

8. On April 15, 2008, respondents' attorney denied treatment of the left upper extremity, indicating that the left upper extremity was under a different claim number and any requests for treatment for that injury should be directed to the adjuster.

9. On April 21, 2008, claimant's attorney wrote to the adjuster for W.C. No. 4-741-385. Claimant once again demanded authorization of treatment for claimant's left upper extremity, asserting that she had overused the left arm because of the ongoing right thumb injury.

10. On April 25, 2008, respondents' counsel wrote to authorize Dr. Dern for evaluation and treatment as necessary for claimant's left upper extremity and authorized care under the original W.C. No. 4-699-837. Respondents noted that they had filed a notice of contest in the new claim (WC 4-741-385). Because of the contest in the new claim, the insurer authorized Dr. Dern to treat the left arm under the original claim.

11. On May 7, 2008, Dr. Dern examined claimant, who reported that she had developed left elbow pain and intermittent swelling in mid-summer 2007. Claimant indicated to Dr. Dern that she had been performing much of her work with her left upper extremity due to her restrictions on her right hand. Dr. Dern diagnosed left elbow pain/epicondylitis due to repetitive strain/overuse. Claimant was referred for treatment, including physical therapy and orthopedic consultation regarding left elbow pain with consideration of cortisone injection.

12. On May 22, 2008, Dr. Allan Bach examined claimant, who reported left elbow pain for the last "few months." Claimant denied any specific injury and attributed this to overuse. X-rays of the elbow were taken on this date. Dr. Bach diagnosed triceps muscle strain or musculotendinous junction strain to be handled by therapy and limitations of activities. No surgical treatment was recommended and injections were not felt appropriate for this problem.

13. On July 8, 2008, Dr. Dern reexamined claimant, who reported continuing worsening of symptoms of left elbow pain due to overuse and her inability to use right hand for repetitive work. Claimant was taken off work to rest her left arm fully. Claimant was placed in an elbow splint and sling for her left arm.

14. On July 21, 2008, respondents filed a GAL in WC 4-699-837 commencing temporary total disability ("TTD") benefits on July 8, 2008, per Dr. Dern's medical report.

15. Claimant continued to obtain conservative care for her left upper extremity. Dr. Castrejon recommended a magnetic resonance image ("MRI"). The August 21, 2008, MRI was normal.

16. On October 14, 2008, Dr. Castrejon examined claimant, who reported mild occasional left upper arm pain that was tolerable with use of Lyrica. Dr. Castrejon diagnosed right CMC arthritis and cyst as well as left elbow epicondylitis and bilateral carpal tunnel syndrome. Dr. Castrejon determined that claimant was at maximum medical improvement ("MMI") and discharged claimant. He recommended post-MMI medical treatment.

17. On October 20, 2008, in WC 4-699-837, respondents filed a Final Admission of Liability ("FAL") terminating TTD benefits, denying permanent disability benefits, alleging an overpayment, and admitting for post-MMI medical benefits.

18. On November 18, 2008, claimant objected to the FAL because it omitted any disfigurement benefit for the right thumb surgery, omitted any permanent disability benefit, and alleged an overpayment.

19. On November 18, 2008, claimant filed an Application for Hearing on the issues of penalties, permanent impairment, and overpayment. Hearing was set for March 10, 2009, and then continued to commence on April 22, 2009.

20. On January 14, 2009, Dr. Dern reexamined claimant, who reported working full duty since MMI and complained of left arm pain. Dr. Dern imposed restrictions on the left arm and referred claimant to Dr. Devanny.

21. On February 10, 2009, Dr. Devanny examined claimant, who reported left arm pain for one month. He referred claimant for an MRI, which was negative. Dr. Devanny then referred claimant for electromyography/nerve conduction studies ("EMG").

22. On May 4, 2009, Dr. Finn examined claimant, who reported increased use of her left arm due to delay in treatment for the right thumb injury. Dr. Finn performed the EMG, which showed radial tunnel syndrome due to a nerve entrapment at the left elbow.

23. The April 22, 2009, hearing was continued until May 13, 2009, due to docket overcrowding and insufficient time to hear the case that day.

24. Claimant requested a prehearing conference. On May 7, 2009, PALJ deMarino conducted the conference and issued an order that granted claimant's Motion to Consolidate W.C. No. 4-699-837 and WC No. 4-741-385 for hearing purposes. PALJ De Marino granted claimant's Motion to Withdraw the Application for Hearing regarding W.C. No. 4-699-837 and to file a successor Application for Hearing on the consolidated claims when MMI for both injuries had been attained.

25. Respondents filed an objection to the prehearing conference order. On May 19, 2009, PALJ deMarino struck respondents' objection.

26. On July 30, 2009, respondents filed an Application for Hearing on the issue of compensability in W.C. No. 4-741-385, "penalties" without further specification, and appeal of the PALJ orders.

27. On September 1, 2009, PALJ Eley granted respondents' request to withdraw the issue of penalties.

28. On August 12, 2009, Dr. Devanny recommended that claimant undergo surgery for a left radial nerve release.

29. There is conflicting evidence for treating the left arm problem as a separate occupational disease or as a natural consequence of the admitted right hand injury. It is the experience of this Judge in the past 20+ years that the parties sometimes separate bilateral problems into two claims and sometimes combine the extremities into one claim. When the parties agree, there is little need for regulatory or adjudicatory inter-

vention. When the parties disagree, the Judge has to decide if there are two separate injuries. In many respects, this hearing was much-ado about nothing. MMI and permanent disability benefits were not issues at the hearing. The only benefit issue was a request for a general order for medical treatment. The insurer had treated the left upper extremity as part of the right hand accidental injury claim in WC 4-699-837 and had filed a FAL for continuing medical benefits in that claim. Either way, the insurer has to treat the left arm. Claimant pursued the claim for the left upper extremity as a separate occupational disease.

30. Claimant has proven by a preponderance of the evidence in WC 4-741-385 that she suffered an occupational disease to her left upper extremity as a natural consequence of her work for the employer. While claimant developed left upper extremity symptoms only after she suffered the right hand injury, her left arm problems arose due to the fact that she returned to work for the employer for many months using her left arm for almost all job duties. That occupational exposure was probably necessary for claimant to develop the left arm disorder. Dr. Dern testified that it was possible that claimant would have developed the left arm injury even without the right hand injury because claimant is left-hand dominant. Dr. Dern admitted that it is impossible to know with certainty because the right hand injury occurred and caused claimant to overuse the left arm. This is not a case in which the left arm problem physiologically flows directly from the right hand injury or from alteration in activities of daily living due to the right hand injury. Claimant worked with right hand restrictions. The continued work for many months using the left arm was a necessary factor for development of the left arm problem. Consequently, claimant suffered an occupational disease to her left arm.

CONCLUSIONS OF LAW

1. Claimant must prove that she is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

2. In WC 4-741-385, claimant alleges an occupational disease to her left upper extremity. Section 8-40-201(14), C.R.S. defines "occupational disease" as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

This section imposes additional proof requirements beyond that required for an accidental injury. An occupational disease is an injury that results directly from the employment or conditions under which work was performed and can be seen to have followed as a natural incident of the work. Section 8-40-201(14), C.R.S.; *Climax Molybdenum Co. v. Walter*, 812 P.2d 1168 (Colo. 1991); *Campbell v. IBM Corporation*, 867 P.2d 77 (Colo. App. 1993). An accidental injury is traceable to a particular time, place and cause. *Colorado Fuel & Iron Corp. v. Industrial Commission*, 154 Colo. 240, 392 P.2d 174 (1964); *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). In contrast, an occupational disease arises not from an accident, but from a prolonged exposure occasioned by the nature of the employment. *Colorado Mental Health Institute v. Austill*, 940 P.2d 1125 (Colo. App. 1997). Under the statutory definition, the hazardous conditions of employment need not be the sole cause of the disease. A claimant is entitled to recovery if he or she demonstrates that the hazards of employment cause, intensify, or aggravate, to some reasonable degree, the disability. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). As found, claimant has proven by a preponderance of the evidence in WC 4-741-385 that she suffered an occupational disease to her left upper extremity as a natural consequence of her work for the employer.

3. Respondents appeal the prehearing conference orders by PALJ deMarino. The first prehearing order consolidated the two claims for hearing purposes, permitted claimant to withdraw her November 18, 2008, application for hearing, and authorized claimant to file another application for hearing on the consolidated claims when MMI had been determined for both injuries. Claimant argues that no statutory procedure exists to appeal a PALJ order to an ALJ at OAC. That is true, but the courts have inferred that the merits ALJ at OAC has the ability to hear such appeals because the merits hearing follows the prehearing. *Industrial Claim Appeals Office v. Orth*, *965 P.2d 1246* (Colo. 1998). In *Brownson-Rausin v. Valley View Hospital*, W.C. 3-101-431 (ICAO, October 3, 2006) and *Szot v. U.S. Security Associates, Inc*., W.C. No. 4-714-229 (ICAO, October 2, 2007), the Panel construed *Orth* as creating a duty for the merits ALJ to consider appeals of all PALJ orders. The standard is “abuse of discretion.” *Brownson-Rausin, supra.* Respondents argue that the PALJ improperly made a finding of fact that claimant was not at MMI. The prehearing order does no such thing. It makes no findings of fact and merely establishes a procedure for claimant to try both claims together. The second prehearing order struck respondents’ “objection” to the prehearing order. The Judge can discern no reason for an objection to an order. Neither the statute nor

any rule of procedure provides for a party to file an objection to an order from a judge. Respondents ultimately correctly filed an application for hearing to appeal the orders. PALJ deMarino did not abuse his discretion in the prehearing orders. Consequently, respondents' appeal is denied and dismissed.

4. Claimant requests attorney fees against respondents pursuant to section 8-43-211(2)(d), C.R.S., for filing an application for hearing on an issue not ripe for adjudication. On July 30, 2009, respondents filed their application for hearing on both claims to determine the issues of compensability in WC 4-741-385 and penalties. On September 1, 2009, PALJ Eley granted respondents' request to withdraw the issue of penalties. The term "ripe for adjudication" refers to a disputed issue concerning which there is no legal impediment to immediate adjudication. *Olivas-Soto v. Industrial Claim Appeals Office*, 143 P.3d 1178 (Colo. App. 2006). Claimant has failed to demonstrate that any legal impediment existed to adjudication of the penalty issue listed by respondents. Claimant's request for attorney fees is denied and dismissed.

ORDER

It is therefore ordered that:

1. In WC 4-741-385, the insurer shall pay for all of claimant's reasonably necessary medical treatment by authorized providers for the left upper extremity occupational disease.

2. Respondents' appeal of the May 7, 2009, prehearing conference order by PALJ deMarino is denied.

3. Claimant's request for attorney fees against respondents for filing an application for hearing on an issue not ripe is denied and dismissed.

4. All matters not determined herein are reserved for future determination.

5.

DATED: January 7, 2010 /s/ original signed by:_____

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-796-064

ISSUES

1. Whether Claimant has established by a preponderance of the evidence that he suffered a compensable injury to his left knee on August 19, 2008 during the course and scope of his employment with Employer.

2. Whether Claimant has demonstrated by a preponderance of the evidence that he received authorized medical treatment that was reasonable and necessary to cure or relieve the effects of an industrial injury.

3. Whether Respondents have proven by a preponderance of the evidence that Claimant is precluded from receiving Temporary Total Disability (TTD) benefits because he was responsible for his termination from employment under §8-42-105(4) C.R.S and §8-42-103(1)(g) C.R.S. (collectively "termination statutes").

FINDINGS OF FACT

1. On May 21, 2007 Claimant began working for Employer as a Locate Technician. His duties required him to spend the majority of his time in the field locating utility and phone lines. Claimant then marked the utilities and sketched the details of their locations.

2. Locate Technician Nathan Brooks testified at the hearing in this matter. He explained that on August 6, 2008 he had worked for Employer for approximately two months. Supervisor Larry Fox assigned Mr. Brooks to a complex locating job that involved entry into manholes. Mr. Brooks remarked that he lacked the experience and required equipment to complete the locating assignment. He thus contacted Mr. Fox for assistance. However, because Mr. Fox was unavailable, he directed Mr. Brooks to contact Claimant for assistance. Claimant was a more experienced locator who possessed the equipment to complete the locating job.

3. Claimant arrived at the locating site to assist Mr. Brooks. He reviewed the computer schematics that revealed all of the utilities involved in the locating job. The schematics reflected two separate duct runs in two separate manholes. A duct run is a group of utility cables wrapped in paper or plastic pipe. Claimant utilized his tools to open one of the manholes and showed Mr. Brooks how to locate the utility lines. Mr. Brooks stated that Claimant taught him how to use a "hot stick" and apply clamps to the relevant utility lines. He noted that Claimant failed to open the second manhole and mark the second duct run.

4. On August 12, 2008 Claimant traveled to Florida for a family vacation. He returned to Colorado on August 18, 2008 and resumed his regular job duties for Employer on August 19, 2008.

5. Claimant testified that on August 19, 2008 he "tweaked" or "wrenched" his left knee while exiting his truck. He stated that he did not immediately experience symptoms, but suffered increased pain and swelling as the day progressed. Claimant reported his injury to Employer on August 20, 2008 but did not specify the cause of his pain.

6. Employer directed Claimant to obtain medical treatment. On August 26, 2008 Claimant visited Brian N. Mathwich, M.D. for an evaluation. Dr. Mathwich noted that Claimant reported "he was in his usual state of health with no injury illness or pain in his knee when he reported to work at 8 o'clock in the morning. He was going about his usual job duties when he began to have some discomfort in his left knee. He denies any specific injury just a gradual onset of pain over several hours." Dr. Mathwich commented that it was difficult to determine whether Claimant's injury was work-related. He explained that Claimant had no previous history of a left knee injury. However, Dr. Mathwich remarked that the absence of an inciting event associated with significant knee swelling was unusual. He placed Claimant on restricted duty and prohibited squatting, bending and climbing.

7. On August 27, 2008 the party that had requested the August 6, 2008 locate job began boring into the ground to install new utility lines. However, the boring machine severed the utility lines that ran out of the second manhole because the location of the duct run was not marked. The cost of repairing the utility damage was approximately $89,000.

8. Claimant remained on restricted duty for Employer and continued to obtain medical treatment. An MRI revealed that Claimant suffered a torn meniscus in his left knee.

9. On September 2, 2008 Claimant was terminated from employment with Employer. Employer's Area Manager Bryan Rich explained that he was involved in the investigation to determine the cause of the damage to the utility lines on August 27, 2008. Mr. Rich stated that Claimant became responsible for the August 6, 2008 locate assignment with Mr. Brooks because he possessed the experience and equipment to complete the job. He commented that the schematics of the job site revealed two separate duct runs involving two manholes. Mr. Rich remarked that it was impossible to locate two duct runs out of a single manhole and it was therefore unreasonable for Claimant to believe that he could locate a second run from a single manhole. He summarized that Claimant was terminated for his negligence in failing to locate the second duct run.

10. Employer's Senior State Director Harley Hartman also testified about the circumstances precipitating Claimant's termination from employment. He commented that he made the decision to terminate Claimant. Mr. Hartman noted that Mr. Brooks did not possess the experience or equipment to complete the August 6, 2008 locate job. Because of Claimant's experience he became primarily responsible for completing the job. Claimant was required to follow the schematics and locate two duct runs. However, because Claimant failed to locate or mark the second duct run and his negligence resulted in significant damage, he was terminated from employment.

11. Margaret Irish, M.D. testified by telephone at the hearing in this matter. She explained that she treated Claimant for his left knee injury. Dr. Irish noted that Claimant did not suffer left knee problems prior to August 19, 2008. However, on August 19, 2008 he suffered a medial meniscus tear that was consistent with exiting a pickup truck. Dr. Irish remarked that the onset of pain from a meniscus tear can be

gradual. She thus concluded that Claimant's knee injury was caused by his employment with Employer on August 19, 2008. Dr. Irish commented that Claimant requires surgery and physical therapy to repair his meniscus tear.

12. Claimant has demonstrated that it is more probably true than not that he suffered a compensable left knee injury on August 19, 2008 during the course and scope of his employment with Employer. Although Claimant did not initially realize the cause of his knee discomfort, he credibly testified that he "tweaked" or "wrenched" his left knee while exiting his truck. Claimant explained that he did not immediately experience symptoms, but suffered increased pain and swelling as the day progressed. Dr. Irish noted that Claimant did not suffer left knee problems prior to August 19, 2008. She persuasively explained that Claimant suffered a medial meniscus tear that was consistent with exiting a pickup truck. Dr. Irish remarked that the onset of pain from a meniscus tear may be gradual. She persuasively concluded that Claimant's left knee injury was caused by his employment with Employer on August 19, 2008.

13. Claimant has established that it is more probably true than not that he received authorized medical treatment that was reasonable and necessary to cure or relieve the effects of his industrial injury. The record reveals that Employer directed Claimant to obtain medical treatment and all of the treatment he received was designed to cure or relieve the effects of his August 19, 2008 knee injury. Furthermore, Dr. Irish persuasively explained that Claimant requires surgery and physical therapy to repair his meniscus tear.

14. Respondents have proven that it is more probably true than not that Claimant is precluded from receiving TTD benefits after September 2, 2008 because he was responsible for his termination from employment. Mr. Rich credibly stated that Claimant became responsible for the August 6, 2008 locate assignment with Mr. Brooks because he possessed the experience and equipment to complete the job. He commented that the schematics of the job site revealed two separate duct runs involving two manholes. Mr. Rich remarked that it was impossible to locate two duct runs out of a single manhole and it was therefore unreasonable for Claimant to believe that he could locate a second run from a single manhole. He summarized that Claimant was terminated for his negligence in failing to locate the second duct run. Finally, Mr. Hartman credibly remarked that he terminated Claimant because Claimant failed to locate or mark the second duct run and his negligence resulted in significant damage.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The

facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

Compensability

4. For an injury to be compensable under the Act, it must "arise out of" and "occur within the course and scope" of employment. *Price v. Industrial Claim Appeals Office*, 919 P.2d 207, 210 (Colo. 1996). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. § 8-41-301(1)(c) C.R.S.; *Faulkner v. Industrial Claim Appeals Office,*12 P.3d 844, 846 (Colo. App. 2000). The question of causation is generally one of fact for determination by the ALJ. *Faulkner,* 12 P.3d at 846.

5. As found, Claimant has demonstrated by a preponderance of the evidence that he suffered a compensable left knee injury on August 19, 2008 during the course and scope of his employment with Employer. Although Claimant did not initially realize the cause of his knee discomfort, he credibly testified that he "tweaked" or "wrenched" his left knee while exiting his truck. Claimant explained that he did not immediately experience symptoms, but suffered increased pain and swelling as the day progressed. Dr. Irish noted that Claimant did not suffer left knee problems prior to August 19, 2008. She persuasively explained that Claimant suffered a medial meniscus tear that was consistent with exiting a pickup truck. Dr. Irish remarked that the onset of pain from a meniscus tear may be gradual. She persuasively concluded that Claimant's left knee injury was caused by his employment with Employer on August 19, 2008.

Medical Benefits

6. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure or relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). It is the Judge's sole prerogative to assess the sufficiency and probative value of the evidence to determine whether the claimant has met his burden of proof. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251, 252 (Colo. App. 1999).

7. As found, Claimant has established by a preponderance of the evidence that he received authorized medical treatment that was reasonable and necessary to cure or relieve the effects of his industrial injury. The record reveals that Employer directed Claimant to obtain medical treatment and all of the treatment he received was designed to cure or relieve the effects of his August 19, 2008 knee injury. Furthermore, Dr. Irish persuasively explained that Claimant requires surgery and physical therapy to repair his meniscus tear.

TTD Benefits

8. Section 8-42-103(1), C.R.S. requires a claimant seeking temporary disability benefits to establish a causal connection between the industrial injury and subsequent wage loss. *Champion Auto Body v. Industrial Claim Appeals Office*, 950 P.2d 671 (Colo. App. 1997). Respondents assert that Claimant is precluded from receiving TTD benefits because he was responsible for his termination from employment pursuant to §8-42-105(4) C.R.S and §8-42-103(1)(g) C.R.S. Under the termination statutes a claimant who is responsible for his termination from regular or modified employment is not entitled to TTD benefits absent a worsening of condition that reestablishes the causal connection between the industrial injury and the wage loss. *In re of George,* W.C. No. 4-690-400 (ICAP July 20, 2006). The termination statutes provide that, in cases where an employee is responsible for his termination, the resulting wage loss is not attributable to the industrial injury. *In re of Davis*, W.C. No. 4-631-681 (ICAP Apr. 24, 2006). A claimant does not act "volitionally" or exercise control over the circumstances leading to his termination if the effects of the injury prevent him from performing his assigned duties and cause the termination. *In re of Eskridge,* W.C. No. 4-651-260 (ICAP Apr. 21, 2006). Therefore, to establish that Claimant was responsible for his termination, Respondents must demonstrate by a preponderance of the evidence that Claimant committed a volitional act, or exercised some control over his termination under the totality of the circumstances. *See Padilla v. Digital Equipment*, 902 P.2d 414, 416 (Colo. App. 1994). An employee is thus "responsible" if he precipitated the employment termination by a volitional act that he would reasonably expect to cause the loss of employment. *Patchek v. Dep't of Public Safety,* W.C. No. 4-432-301 (ICAP, Sept. 27, 2001).

9. As found, Respondents have proven by a preponderance of the evidence that Claimant is precluded from receiving TTD benefits after September 2, 2008 because he was responsible for his termination from employment. Mr. Rich credibly stated that Claimant became responsible for the August 6, 2008 locate assignment with Mr. Brooks because he possessed the experience and equipment to complete the job. He commented that the schematics of the job site revealed two separate duct runs involving two manholes. Mr. Rich remarked that it was impossible to locate two duct runs out of a single manhole and it was therefore unreasonable for Claimant to believe that he could locate a second run from a single manhole. He summarized that Claimant was terminated for his negligence in failing to locate the second duct run. Finally, Mr. Hartman credibly remarked that he terminated Claimant because Claimant failed to locate or mark the second duct run and his negligence resulted in significant damage.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant suffered a compensable left knee torn meniscus injury during the course and scope of his employment with Employer on August 19, 2008.

2. Claimant is entitled to reasonable and necessary medical benefits, including surgery and physical therapy, which are designed to cure or relieve the effects of his August 19, 2008 left knee injury.

3. Because Claimant was responsible for his termination from employment with Employer he is precluded from receiving TTD benefits after September 2, 2008.

4. Any issues not resolved in this order are reserved for future determination.

DATED: January 5, 2010

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-553-026

ISSUES

- Whether Claimant's claim should be reopened based upon a change in condition; and
- Whether Claimant is entitled to ongoing medical treatment.

FINDINGS OF FACT

Based on the evidence presented at hearing, the Judge finds:

1. Claimant sustained a compensable industrial injury to his right hand on August 21, 2002, when a truck door closed onto his hand. He was paid temporary disability benefits until December 8, 2004, and a Final Admission of Liability was filed on August 1, 2005, based upon a Division Independent Medical Examination ("DIME") performed by Alexander Jacobs, M.D.

2. Claimant was placed at maximum medical improvement ("MMI") on December 8, 2004. Respondents admitted for medical maintenance care after the date of MMI and continued to pay for medical benefits subsequent to that date.

3. Claimant filed a Petition to Reopen on August 20, 2008 based upon a change in medical condition. The only document attached to the Petition to Reopen was an affidavit from the Claimant indicating that his condition was worse, that he was experiencing more pain and that he was "unable to work."

4. Claimant treated with multiple physicians following his work injury including George Schakaraschwili, M.D. Dr. Schakaraschwili concluded that Claimant had developed Complex Regional Pain Syndrome ("CRPS") in his right hand due to objective autonomic dysfunction as measured by QSART testing and objective physical symptoms. Dr. Schakaraschwili also noted that there was a significant functional component to Claimant's presentation. He indicated that the Claimant had reactions to medications and that he developed a "phobia to physical therapy." Dr. Schakaraschwili found that although the Claimant's objective condition had improved that his complaints of pain had not. Dr. Schakaraschwili noted that Claimant was difficult to assess because of the significant functional overlay in most of his responses. Nevertheless, Dr. Schakaraschwili continued to diagnose Claimant with CRPS.

5. In December 2004, Dr. Scakarascwili noted that Claimant had complained of pain in his left upper extremity, but there was no convincing evidence that the CRPS had spread.

6. Claimant was also seen by a psychologist, Dr. Bar-Navon. He advised her that he had never been hospitalized for mental health reasons although he had previously been diagnosed with chronic fatigue. However prior medical records indicated that the Claimant had symptoms of chronic fatigue most of his life. He had been diagnosed with depression prior to this injury and advised doctors that he had been admitted into a psychiatric hospital because of depressive symptoms.

7. Claimant saw Dr. Jacobs for the DIME in June 2005. Dr. Jacobs concluded that Claimant had CRPS in his right hand and assessed an impairment rating for the condition.

8. In October 2005 Claimant was seen by Richard L. Stieg, M.D. Dr. Stieg found "clear-cut evidence of symptom magnification, probably representing Factitious Disorder and/or some malingering behavior superimposed on Diagnosis 1." He also felt that the Claimant had a "physical dependence on opiods" and recommended that Claimant be taken off opiate medications. Since he found that there was unreliability of Claimant's objective findings, Dr. Stieg felt that it was inappropriate to continue maintenance on opiate drugs.

9. Claimant moved to Utah in 2005 and his medical care was transferred to Mark Passey, M.D. Dr. Passey took over the Claimant's care in March of 2005. At that time,

the Claimant was alleging that he had pain on a level of 9 out of 10. Claimant alleged that he was unable to work. Dr. Passey stated that "the appearance of the right hand versus the left hand is most noticeable for how unremarkable the right hand looks. There is indeed some erythema as opposed to the left, but there is no skin atrophy, no muscle atrophy, no hair loss, no temperature difference to gross touch, no difference in sudomotor to gross touch. The only finding on physical exam, really, is that he has extreme allodynia to light touch." Dr. Passey noted that the Claimant had a prior history of chronic fatigue syndrome and fibromyalgia and that the Claimant told him that he had been on full disability for three years for chronic fatigue syndrome. Dr. Passey stated that "in my estimation, this gentleman is fully prepared to take the path of least resistance back onto disability. In my opinion, this is unnecessary and counter productive and I will require him to show signs of rehabilitation if he is to remain my patient in terms of me prescribing him opiates."

10. Dr. Passey continued to treat the Claimant but stated that the diagnosis of complex regional pain syndrome was only made "virtually solely on his report of pain." Dr. Passey highly recommended that the Claimant be taken off his opiate medications and that he thought the Claimant was attempting to "obtain a compensated disability status." He stated "it is possible for opiate prescribing to reinforce pain-complaint related functional deterioration, and it behooves pain practitioners to avoid this."

11. Dr. Passey advised the Claimant that he was going to taper him off his opiods. Therefore, Claimant went back to Colorado and obtained opiates from Dr. Schakaraschwili. Dr. Passey then noted in his report of January 17, 2006, that this was a violation of his opiate agreement and that the Claimant did not wish to be treated by Dr. Passey. Dr. Passey stated that he would not prescribe any more opiates to the Claimant. Claimant wanted to be referred to Life Tree Pain Clinic and Dr. Webster. However, Dr. Passey would not agree and referred Claimant to University of Utah Pain Management Center.

12. Claimant came under the care of the physicians at the University Pain Management Center at the University of Utah in 2006. Dr. Brogan noted a very questionable diagnosis of CRPS given that there were minimal or no physical findings. Dr. Brogan also indicated that he was very reluctant to prescribe opiates to the Claimant.

13. During the time that the Claimant was being treated at the University of Utah Pain Management Center, surveillance was performed which has been reviewed by the Administrative Law Judge. In 2006, Claimant was observed driving a vehicle and utilizing both arms to carry a sofa, climb up and down a ladder and work on a boat utilizing several tools. However, at that time, he was advising the doctors he could not fish or fold laundry due to his pain.

14. After Claimant was discharged by Dr. Passey, he was seen by a psychologist, Darrell Hart, Ph.D. in June of 2006. At that time, Claimant advised Dr. Hart that he felt his "RSD had moved into his right elbow and to his right shoulder. He also was claiming a problem with the left upper extremity and advised Dr. Hart that "I've read that RSD can

migrate. Dr. Hart found a somatic component to the Claimant's presentation and stated that he was pessimistic about the effectiveness of any behavioral medicine intervention because of the Claimant's psychological overlay. He noted that "an effort to reduce the use of highly potent and addictive pain medications was met with resistance to the point of seeking another doctor." Dr. Hart noted that Claimant was again seeking financial security through Social Security Disability benefits and was also again complaining of chronic fatigue symptoms.

15. After Claimant was discharged by the University of Utah Pain Management Center, his care was transferred to Bruce Newton, M.D. who took over care in mid-2006. He advised the Claimant that he was willing to accept the Claimant for maintenance treatment as long as there was "an honest interest in return to function and getting off of pain medicine." However, he indicated that he was unconvinced that the Claimant had "great interest in either of those endeavors." He indicated Claimant was applying for Social Security Disability based on three diagnoses that were "very sketchy" and included fibromyalgia, chronic fatigue syndrome and complex regional pain syndrome. He felt that all of the Claimant's conditions were, for the most part, subjective and that none of these diagnoses could be substantiated.

16. Dr. Newton also had the opportunity to review the surveillance video that had been taken of Claimant in 2006. He noted that, although the Claimant carried a diagnosis of complex regional pain syndrome, that this was only a "possible" diagnosis as the Claimant had not demonstrated positive findings on examination to qualify for an objective diagnosis of CRPS according to the AMA Guides. He felt that the Claimant should come off of all opiate medication but that the Claimant "resists this greatly" and that he did not believe the Claimant would "proceed in that direction." Dr. Newton in 2006 strongly encouraged the tapering of Claimant's opiate medications and then referred the Claimant's maintenance care to his family physician, David Jack, M.D.

17. Dr. Jack had been Claimant's family physician before he began treating Claimant for the industrial injury. Dr. Jack took over the Claimant's care for his workers' compensation claim in 2006 and has seen him on a monthly basis since that date. Dr. Jack has not made any effort to wean Claimant from his opiate medications but has increased those medications over the last three years.

18. Respondents at no time challenged whether the treatment recommendations of Dr. Jack were reasonable and necessary to maintain Claimant's condition.

19. Dr. Jack noted in August of 2006 that the Claimant had "chronic fatigue" and that he suspected "histrionic" symptoms. In October of 2007 he noted that Claimant's right hand was swollen but there were "lots of calluses on right hand". At that time he indicated, "I need to consider secondary gain with large calluses on right hand. He clearly overstates the sensitivity while in the office." In February of 2008, Claimant advised Dr. Jack that "the left leg now has RSD and gives out on him and now he has to use a cane."

20. Claimant was re-evaluated by Dr. Newton in April of 2009. At that time Claimant advised Dr. Newton that he now had CRPS in his left arm and in his left lower extremity. He also claimed that he had been diagnosed with central sleep apnea and hypogonadism related to his chronic opiate use over the years. Dr. Newton again stated that the Claimant did not meet the criteria for CRPS based upon the AMA 5th Edition Impairment Guidelines but instead had a somatization disorder. In addition, Dr. Newton found no evidence of CRPS in either the left upper extremity or left lower extremity. He felt that the Claimant's chronic pain was "perpetuated by his chronic opiate use". Based on Dr. Newton's examination, he found no objective worsening of the Claimant's condition and no evidence of "spreading" of the alleged CRPS.

21. Claimant was seen at the request of Dr. Jack by Lynn Webster, M.D. in May of 2009. Dr. Webster opined that the Claimant had no objective findings involving his left upper extremity or his left lower extremity and did not believe Claimant suffered from CRPS in either the left upper or left lower extremity. In regards to the Claimant's alleged chronic fatigue syndrome, he indicated this would not be due to the CRPS and that the Claimant was not experiencing chronic fatigue syndrome related to the CRPS.

22. According to Dr. Webster, the Claimant had advised him that his condition "has worsened over time". He agreed that the Claimant's use of opiate medications over the last three years had not improved his function and that it was "just a matter of reducing the intensity of his pain and that would, of course, be subjective, that he would report." In addition, Dr. Webster agreed that there was no evidence of any atrophy in the Claimant's right upper extremity.

23. Dr. Newton's testimony was taken by deposition on September 21, 2009. He indicated that during the period of time he was treating the Claimant back in 2006 that Claimant had a bone scan performed which was negative with no evidence of CRPS. He stated that, at the time the Claimant began treating with him back in 2006, he had already applied for Social Security Disability benefits and was considering himself "non-functional."

24. When Dr. Newton re-examined the Claimant in 2009, the Claimant advised him that his CRPS had allegedly "spread" to his left upper extremity and left lower extremity. However, Dr. Newton found no evidence of any objective findings or CRPS in either the left upper extremity or the left lower extremity.

25. Dr. Newton had recommended that the Claimant be weaned from his medications when he transferred his care to Dr. Jack. However, he indicated that in the three years Claimant had been treating with Dr. Jack, there had been no effort to wean Claimant from his opiate medications. Dr. Newton found minimal changes on examination between 2006 and 2009. Dr. Newton did feel that the Claimant had a somatoform pain disorder and noted that even Dr. Jack had referred to the fact that Claimant had calluses on his right hand which indicated the use of the upper extremity beyond what the Claimant alleged. He noted that Dr. Jack had even mentioned that he needed to consider secondary gain.

26. In 2009 Dr. Newton again recommended that the Claimant be weaned from his chronic opiate medications. He stated that, although the Claimant would be "worse temporarily", that he believed "strongly that in the long run he would be better off being off of the medicine." Dr. Newton noted that one of the purposes of giving an individual opiate medication was to make them more functional and that in Claimant's case, he was claiming back in 2006 that he was unemployable and he was still claiming at the present time that he was unable to work. There is no indication that the ongoing use of opiate medication has improved either the Claimant's function or his pain.

27. Dr. Newton commented upon the recommendations made by Dr. Webster for an antibiotic medication, Ketamine infusion and a potential stimulator. Dr. Newton opined that it would be unlikely that the Claimant would respond to any of the recommendations based upon the fact that he was skeptical about the diagnoses and also that the Claimant had been through various pain clinics both in Colorado and in Utah. He noted "no treatments have ever made a difference for him and I would not expect Dr. Webster's interventions to be superior to what's been tried up to this point." The opinions and recommendations of Dr. Newton concerning Claimant's ongoing use of opioids and worsening or spreading of CRPS are persuasive. Dr. Newton's opinions concerning Claimant's need for ongoing treatment of the CRPS as recommended by Dr. Webster are persuasive.

28. The Claimant's date of birth is July 6, 1972 and he is presently 37 years old. According to Claimant's testimony, at the time his case was closed in 2006, he did not believe that he was able to work. He applied for Social Security Disability benefits and was denied and has reapplied. Since 2006 the Claimant has not worked and does not feel he is able to work at the present time.

29. The Claimant testified that the "worsening" of his condition upon which his Petition to Reopen is based is not that his pain has changed in any respect. Instead he indicates that it is just "gotten over a broader area." He indicated that the "worsening" that has occurred is in his right shoulder, left upper extremity and left lower extremity. He also feels that his chronic fatigue syndrome has been "aggravated" by his CRPS. According to the Claimant, since 2006 his pain hasn't gotten worse but is "encompassing a greater area of his body" since his CRPS has allegedly spread to his left upper extremity and his left lower extremity. He stated his pain rating remained pretty constant but that what has changed is the "area affected by pain."

30. Not only do the medical records indicate that Claimant complained that the CRPS was "spreading" into other areas of his body before his claim closed, there is no persuasive or credible evidence that Claimant's CRPS has indeed spread. Claimant does not suffer from CRPS in either the left upper extremity or left lower extremity and does not require medical care and treatment for such conditions. Therefore he has not established a "change in his condition" due to the alleged spread of the CRPS. Claimant has further failed to establish that the CRPS in his right hand has worsened.

31. Dr. Stieg, Dr. Passey and Dr. Newton have all recommended that the Claimant be tapered off of his opiate medications. This was the recommendation made by Dr. Newton at the time that he transferred the Claimant's care to Dr. Jack. However, Dr. Jack did not wean Claimant from his opiate medication but in fact has increased the medications since 2006. Claimant testified that he is willing to comply with an opiate weaning program if required to do so. Appropriate maintenance care and treatment for Claimant would be to wean him from the medications as recommended by Dr. Newton.

32. Dr. Jack diagnosed Claimant with central sleep apnea following a sleep study. Dr. Webster opined that the sleep apnea may be due in part to a chronic neurologic disorder and could be due to chronic opioid therapy. Dr. Webster stated that if claimant was suffering from obstructive sleep apnea, it is most often due to physical habitus. He stated that central sleep apnea, however, is unrelated to physical habitus. There is no evidence in the medical records that Claimant suffered from sleep apnea in the past.

33. Drs. Jack and Webster noted that the Claimant was also suffering from hormone levels out of the normal range. Specifically, the claimant's hormone problem was associated with thyroid and testosterone. He opined that the most common cause of testosterone deficiencies in chronic pain patients is due to chronic opioid therapy. There is no persuasive evidence, however, that Claimant's thyroid abnormalities are related to the opioid use.

34. Dr. Webster opined that the diagnosed Central Sleep Apnea and testosterone deficiencies were associated with the work injury related treatments and that these conditions remain untreated.

35. Dr. Webster opined that he did not believe the claimant was experiencing Chronic Fatigue Syndrome from CRPS.

36. Based on the foregoing, Claimant has established that he has developed central sleep apnea and testosterone deficiency as a result of chronic opioid use. Claimant's authorized treating physicians prescribed the opioids to cure and relieve Claimant of the effects of his admitted work injury. Accordingly, the sleep apnea and thyroid deficiency is causally related to the work injury. There was no persuasive evidence that either of these conditions was present when Claimant was placed at maximum medical improvement. Further, the medical reports and testimony that Claimant developed both of these conditions as a result of long-term opioid use was essentially uncontested. Claimant, therefore, has established that his condition has changed.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Judge enters the following conclusions of law:

1. The purpose of the “Workers’ Compensation Act of Colorado” is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo.App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness’s testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); CJI, Civil 3:16 (2005).

Reopening

4. Section 8-43-303(1), supra, provides:

> At any time within six years after the date of injury, the director or an administrative law judge may … review and reopen any award on the ground of fraud, an overpayment, an error, a mistake, or a change in condition ….

5. Claimant shoulders the burden of proving his condition has changed and his entitlement to benefits by a preponderance of the evidence. Section 8-43-201, *supra*; *see Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to change in claimant's physical or mental condition which can be causally connected to the original injury. *Chavez v. Industrial Commission,* 714 p.2d 1328 (Colo. App. 1985).

6. As found, Claimant has established that his claim should be reopened based upon a change in his condition. Claimant sustained an admitted injury to his right hand in 2002. Such injury resulted in a diagnosis of CRPS in his right hand for which he was prescribed opioid medications. While it is true that many of Claimant’s physicians, including a DIME physician, commented on Claimant’s lack of CRPS symptoms, they nevertheless diagnosed him with the condition and provided treatment for it. The long-term opioid use has now caused Claimant to develop central sleep apnea and testos-

terone deficiency. There is no persuasive evidence that either of these conditions was present when Claimant was placed at maximum medical improvement. Further, the medical reports and testimony that Claimant developed both of these conditions as a result of long-term opioid use was essentially uncontested.

With respect to the CRPS, Claimant has not established that the CRPS itself has worsened. Claimant specifically testified that his pain levels are the same, but that the pain currently encompasses more of his body than just his right hand. Claimant believes the CRPS has spread; however, there is no persuasive medical evidence that CRPS has spread to any other part of his body. Thus, Claimant's right hand condition in and of itself has not changed.

To the extent Claimant contends that he has developed chronic fatigue syndrome or hypothyroidism as a result of his work injury, such contentions are not supported by the credible medical evidence. Claimant indeed acknowledged that the thyroid condition was not related to his work injury and that he previously suffered from chronic fatigue syndrome.

Claimant's claim is hereby reopened based upon the new diagnoses of central sleep apnea and testosterone deficiency caused by long-term opioid use which was prescribed to treat Claimant's work-related right hand injury. Claimant's CRPS has neither worsened nor spread.

Medical Benefits

7. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial* Commission, 759 P.2d 705 (Colo. 1988). Here, Claimant has established that he is entitled to treatment for central sleep apnea and testosterone deficiency. He is further entitled to any other treatment that is reasonable, necessary and related to his workers' compensation injury other than the treatment specifically denied herein.

As found, Claimant has failed to establish that he is entitled to continued opioid medications because such medications are no longer reasonable and necessary. The opinions of Dr. Newton are more persuasive than those of Drs. Jack and Webster concerning Claimant's medical treatment requirements for CRPS. Despite the opinions of both Drs. Jack and Webster that Claimant's sleep apnea and testosterone deficiencies are caused by opioid use, they both support Claimant's continued use of opioids. In addition, at least three physicians who have treated or evaluated Claimant have opined that Claimant should be weaned from opioids. Claimant's continued pain complaints and lack of functioning clearly indicate that the opioids are not improving his functioning. The Judge agrees that Claimant should be weaned from opioids and that the weaning constitutes reasonable and necessary medical treatment. Accordingly, Claimant has failed to establish that ongoing opioid medications, other than prescribed through the weaning process, are reasonable and necessary.

Claimant has also failed to establish that Dr. Webster's treatment recommendations are reasonable and necessary to cure and relieve him from the effects of the injury. As opined by Dr. Newton, Claimant has seen little or no relief with prior treatments due to the psychological component of his pain complaints. The opinion of Dr. Newton that Claimant would not benefit from additional procedures or treatment for the CRPS is persuasive.

ORDER

It is therefore ordered that:

1. Claimant's claim is reopened due to a change in his condition, specifically the development of central sleep apnea and testosterone deficiency due to chronic opioid use.
2. Claimant is entitled to reasonable and necessary medical treatment related to his work injury other than the treatment specifically denied herein.
3. Claimant is not entitled to continued opioid therapy other than through a weaning process. Continued use of opioids is no longer reasonable and necessary.
4. Claimant's CRPS has not worsened or spread. Claimant is not entitled to the treatment recommendations made by Dr. Webster, which included antibiotics and Ketamine injections. Such treatment recommendations are not reasonable and necessary.
5. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
6. All matters not determined herein are reserved for future determination.

DATED: January 6, 2010

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-799-935

ISSUES

The issue determined herein is medical benefits. At the hearing, respondents stipulated that claimant suffered a compensable work injury.

FINDINGS OF FACT

1. Claimant has been experiencing low back since the mid-1990's and his personal physician, Dr. Duncan, had provided intermittent treatment.

2. On July 12, 2006, Dr. Jenks examined claimant, who reported a history of intermittent low back pain on and off for about ten years. Dr. Jenks diagnosed degenerative arthritis and referred claimant for physical therapy and for a magnetic resonance image ("MRI").

3. The July 13, 2006, MRI scan revealed multi-level disc bulges and protrusions and associated canal stenosis and potential nerve root mass-effect and/or irritation, most prominent at the L3-4 and L4-5 levels.

4. Claimant received physical therapy. In September 2006, Dr. Jenks administered a right L4-5 epidural steroid injection ("ESI"), which provided significant pain relief. By September 28, 2006, Dr. Jenks noted that claimant's low back pain was "essentially gone."

5. Claimant was involved in a motor vehicle accident on February 28, 2007. The accident occurred when a driver in a Hummer rear-ended claimant's vehicle. Claimant reported pain radiating into his right buttock and hip region along with low back pain.

6. Dr. Hall treated claimant for the motor vehicle accident. He referred claimant for physical therapy and massage therapy and referred claimant back to Dr. Jenks.

7. On July 10, 2007, D. Jenks diagnosed an aggravation of L3-4 and L4-5 spinal stenosis and administered an ESI at L4-5. On August 7, 2007, Dr. Jenks noted that the ESI provided good results and claimant had no low back pain or leg pain, although he had residual problems with his upper back.

8. Dr. Hall continued to treat claimant's upper back, including Botox injections in the upper back and neck.

9. Claimant then suffered increased low back problems and returned to Dr. Jenks on April 1, 2008, reported continued low back pain, but no leg pain. Dr. Jenks referred claimant for another MRI. The April 4, 2008, MRI showed multi-level degenerative changes with the most significant findings at L3-4 and L4-5.

10. On May 5, 2008, Dr. Jenks administered another ESI on the right at L4-5. On May 27, 2008, claimant reported that he obtained only a "few days" of pain relief from the ESI. He noted that the neck pain comes and goes. Dr. Jenks recommended treating the low back only on an as-needed basis.

11. Commencing June 4, 2008, Chiropractor Abercrombie commenced treatment of claimant's neck, but he noted that claimant also reported low back and bilateral leg pain. The chiropractor apparently also treated claimant's low back problems.

12. On July 14, 2008, Dr. Jenks administered another ESI on the right at L4. On September 2, 2008, claimant reported to Dr. Jenks that the ESI only provided "minimal relief of his low back pain." Dr. Jenks diagnosed possible facet irritation at L4-5 and L5-S1 and recommended bilateral L4-5 and L5-S1 facet injections for diagnostic and therapeutic purposes. Claimant did not immediately receive these injections.

13. Chiropractor Abercrombie treated claimant through December 8, 2008. Due to claimant's ongoing pain without improvement, Chiropractor Abercrombie referred claimant back to Dr. Jenks for consideration of medical branch blocks."

14. As of January 2009, claimant was still able to engage in various activities, including hiking, golfing, and work around the house. He had low back pain, but only a "little" leg pain.

15. On January 27, 2009, claimant suffered admitted injuries in a motor vehicle accident while working for the employer. Another vehicle rear-ended claimant's vehicle at a fairly low rate of speed while claimant was stopped with his body turned to one side. Claimant's car was still operable after the accident. As a result, claimant drove himself to Memorial Hospital ER and complained of headache, neck pain, and back pain. Claimant had a computed tomography ("CT") scan of the neck, which showed arthritic and osteophytic changes. A CT of the head showed possible old cerebrovascular accident. Claimant received pain medications.

16. On January 28, 2009, Dr. Jenks reexamined claimant, who reported neck pain and low back pain radiating to his right leg. Dr. Jenks indicated that 50% of claimant's need for medical treatment was due to the new work injury. He referred claimant back to Chiropractor Abercrombie. Dr. Jenks also referred claimant for medial branch blocks, but noted that the need for these blocks was not due to the work injury.

17. On February 16, Dr. Jenks administered medial branch blocks at L3-L5.

18. A February 20, 2009, MRI of the lumbar spine showed no changes. The radiologist noted that the MRI no longer showed a possible synovial cyst previously found on the April 4, 2008, MRI. The MRI showed degenerative disc disease and facet athrosis from L2 to S1, as well as right L4 nerve root compression.

19. On February 24, 2009, Chiropractor Abercrombie noted that he thought that 30% of claimant's symptoms were due to the work injury. He did not explain his apportionment.

20. On March 2, 2009, Dr. Jenks administered another ESI on the right at L4-5 in addition to a rhizotomy bilaterally at L3 to L5.

21. On April 14, 2009, Dr. Jenks examined claimant, who reported temporary improvement with no left-sided low back pain, but a return of right-sided low back pain and radiating pain into the right leg.

22. On May 7, 2009, Chiropractor Abercrombie noted that claimant still reported low back and right leg pain and indicated that he would treat claimant's neck three more times.

23. On June 15, 2009, Dr. Jenks noted claimant suffered worsening low back pain and leg pain. Dr. Jenks diagnosed facet and discogenic pain.

24. On August 20, 2009, Dr. Jenks noted worsening low back and left leg pain. He prescribed Hydrocodone and acupuncture and referred claimant for a surgical consultation.

25. Claimant received acupuncture treatment from August 24 through October 21, 2009.

26. On October 27, 2009, Dr. Mark Paz performed an independent medical examination for respondents. He reviewed the MRI films and found no interval changes. Dr. Paz concluded that claimant suffered only a lumbar strain in the January 2009 work injury. Dr. Paz diagnosed degenerative disc disease and arthritis, which continued to deteriorate even without the work injury. He thought that 2% of claimant's condition at that time was due to the work injury.

27. Dr. Paz testified at hearing consistent with his report that claimant's current condition was not caused by the work injury. He thought that claimant's ongoing condition after a month or two was not work-related and that claimant would have had the same physical condition on an ongoing basis whether or not the work injury occurred. Dr. Paz conceded that claimant did not need any pain medications until after his work injury, had no sleep problems until after the work injury, was able to engage in his non-work activities until the work injury, and had no referral for surgery consultation before the work injury.

28. Claimant had significant preexisting low back problems, for which he received treatment in 2006 that resolved his symptoms. He suffered injuries in a February 28, 2007, motor vehicle accident, causing neck, upper back, low back, and leg pain. Dr. Jenks administered epidural steroid injections that greatly improved claimant's low back and leg pain in August 2007. In April 2008, claimant complained of continued low back pain. He got only a few days of relief from a repeat right L4-5 ESI in May 2008. Dr. Jenks diagnosed facet syndrome L4 to S1 and recommended medial branch blocks. Claimant tried some chiropractic treatment without success and was referred back to Dr. Jenks for the medial branch blocks. At that time, claimant was still able to hike, golf, and do work around his house.

29. Claimant then suffered the neck and low back injuries in the January 27, 2009 motor vehicle accident. Claimant suffered increased right leg pain from the work injury. Dr. Jenks immediately indicated that the medial branch blocks were not due to the work injury, but he indicated that claimant should return to the chiropractor and that 50% of that treatment was due to the work injury. Repeat MRI studies showed no significant change from previous studies before the work injury. The medial branch blocks were administered and then followed on March 2, 2009, with rhizotomies bilaterally L3 to L5.

Dr. Jenks also administered another right L4-5 ESI. On April 14, 2009, claimant reported improvement in left sided low back pain, but he had return of right low back pain and right leg pain. Dr. Jenks subsequently noted that claimant's condition was worsening and diagnosed him with facet and discogenic problems. Dr. Jenks subsequently referred claimant to Dr. Sabin for a surgical consultation.

30. The preponderance of the record evidence does not support respondents' argument that claimant returned to his pre-injury baseline condition by March 27, 2009, or even by April 14, 2009. Respondents are correct that Dr. Jenks has not addressed causation or apportionment since January 28, 2009. Apparently, that is because nobody asked him, which is unfortunate because he has by far the longest-running clinical experience with claimant.

31. Respondents sought to cease all liability for medical benefits as of March 27, but the preponderance of the evidence does not demonstrate that claimant returned to his pre-injury baseline condition. Claimant's condition definitely was worsened in the work injury. Dr. Paz might be correct that claimant's condition currently would be the same even without the work injury, but the trier-of-fact cannot find that proposition is probably true. The parties did not litigate any specific medical treatment and did not obtain any updated assessment from Dr. Jenks, whose opinions are highly persuasive in this case. The work injury caused at least a temporary aggravation of claimant's condition and that aggravation has not yet resolved.

CONCLUSIONS OF LAW

1. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Respondents conceded that claimant suffered temporary aggravations of his preexisting degenerative back condition, but argued that he had returned to pre-injury baseline condition as of March 27, 2009. Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). As found, the preponderance of the record evidence does not support respondents' argument that claimant returned to his pre-injury baseline condition by March 27, 2009, or even by April 14, 2009. Respondents did not seek any apportionment of specific medical treatments. No such apportionment is addressed in this order. Consequently, respondents remain liable for medical benefits for the work injury.

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of claimant's reasonably necessary medical treatment by authorized providers for his work injury, including Dr. Jenks and his referrals. All matters not determined herein are reserved for future determination.

DATED: January 7, 2010

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-669-749

ISSUES

The sole issue determined herein is penalties against the insurer pursuant to section 8-43-304, C.R.S, for violation of OACRP 15.

FINDINGS OF FACT

1. Claimant suffered an admitted industrial injury on November 26, 2005.

2. On August 15, 2008, Mr. Irwin, the previous attorney for respondents, filed an Application for Hearing and Notice to Set ("application") on the issues of compensability and maximum medical improvement ("MMI").

3. Mr. Irwin filed the application to obtain a ruling regarding the relatedness of various body parts and injuries to the admitted work injury.

4. On August 26, 2008, claimant's attorney, Mr. Mullens, filed a motion to strike respondents' application. On September 4, 2008, claimant filed her response to the application, adding issues of penalties and attorney fees against respondents.

5. On September 5, 2008, Mr. Irwin filed an objection to the motion to strike the application. Claimant's motion was denied on September 9, 2008. A Notice of Hearing was issued on September 5 for a December 10, 2008, hearing.

6. Mr. Irwin and Mr. Mullens have one of the most dysfunctional, conflicted relationships ever manifested by two opposing attorneys. Mr. Irwin developed a policy of never orally communicating with Mr. Mullens.

7. At 2:43 p.m., October 17, 2008, Mr. Irwin sent a facsimile transmission of a letter to Mr. Mullens, which stated as follows:

> "Pursuant to the September 22, 2008 MMI and impairment report of Dr. Quick, respondents will be filing a Final Admission of Liability consistent therewith. Therefore, the issues endorsed by respondents in their current Application for Hearing are moot. It is respondents' intent to withdraw their Application for Hearing and to cancel the hearing scheduled for December 10, 2008. Please inform in writing by the close of business Tuesday, October 21, 2008, as to whether or not claimant has any objection to the withdrawal of respondents' Application for Hearing and the currently-scheduled hearing date.

8. Mr. Irwin wanted to withdraw the application and vacate the December 10 hearing because, after respondents filed the application, the authorized treating physician, Dr. Quick, issued a report indicating that the claimant had reached MMI for all conditions, thereby rendering moot the issues set forth in the application.

9. Mr. Irwin gave Mr. Mullens a period of about five days to respond to proposed actions before taking action because that had been his custom and practice with Mr. Mullens on previous cases. Mr. Irwin believed that if Mr. Mullens were out of the office when the October 17, 2008 correspondence was received, another staff member from Mr. Mullens' office would review the correspondence and respond by October 21, 2008.

10. On October 21, 2008, the insurer filed a final admission of liability.

11. On October 22, 2008, respondents filed a Notice of Withdrawal of Application for Hearing and a Hearing Cancellation form. The cancellation form for the December 10 hearing contained a check in the box verifying that respondents had conferred with the opposing party and the opposing party agreed to cancel the hearing. Mr. Irwin instructed his legal assistant to prepare and file these documents.

12. Mr. Irwin canceled the hearing because Mr. Mullens had not contacted him to object to vacating the hearing, as he requested in his October 17, 2008 letter. Mr. Irwin believed Mr. Mullens would not object to canceling the hearing because previously Mr. Mullens had filed a motion seeking to strike Mr. Irwin's August 15, 2008 application.

13. After respondents filed the cancellation form, Mr. Mullens mailed a letter to Mr. Irwin, objecting to canceling the hearing unless respondents paid claimant's attorney fees and costs. Mr. Irwin received this letter on October 23, 2008.

14. On October 23, 2008, claimant filed her motion to retain the December 10, 2008 hearing date. On November 3, 2008, Mr. Irwin filed an objection to that motion. On November 4, 2008, claimant's motion was granted.

15. The hearing went forward as scheduled on December 10, 2008 and claimant proceeded on her endorsed issues against respondents. On February 19, 2009, Judge Walsh issued his order denying a penalty for alleged dictation of medical care, but

awarding claimant attorney fees and costs for the application for hearing on an unripe issue of MMI.

16. Mr. Irwin filed a cancellation form without agreement of all parties or an order of a Judge. Mr. Irwin had no reasonable basis to believe that Mr. Mullens agreed to cancel the December 10, 2008, hearing. The failure of Mr. Mullens to respond within four calendar days after the faxed October 17 letter would reasonably satisfy Mr. Irwin's obligation to confer prior to filing a motion to vacate the December 10 hearing. It did not provide a reasonable basis for Mr. Irwin to believe that claimant agreed to cancel the hearing. Mr. Irwin's filing of the cancellation form with the check in the box to verify that all parties agreed was an unreasonable violation of OACRP 15. Consequently, the insurer committed an unreasonable violation of OACRP 15.

17. The insurer's violation of OACRP 15 arose out of the conflicted, dysfunctional relationship between the two opposing attorneys. This Judge is aware that, from time to time, one party believes an agreement exists to cancel a hearing when, in fact, the opposing party does not agree. Mr. Irwin did not have any reasonable belief that agreement existed. Mr. Irwin apparently did not understand the distinction between his duty to attempt to confer before filing a motion to strike the application and his duty actually to confer and obtain agreement before submitting the hearing cancellation form. If Mr. Irwin actually understood the distinction, but misrepresented agreement, his violation would warrant the maximum $500 penalty. Because Mr. Irwin misunderstood his duty, the violation warrants a lesser penalty. The violation did not result in any significant harm. The violation by the insurer was quickly remedied because OAC put the hearing back on the docket. The hearing proceeded as scheduled. Nevertheless, the violation is not *de minimus*. The penalty needs to be sufficient to dissuade future violations. The Judge determines that a penalty of $100 is appropriate for the violation.

CONCLUSIONS OF LAW

1. Claimant seeks a penalty pursuant to section 8-43-304(1), C.R.S. due to respondents' alleged violation of OACRP 15. Section 8-43-304(1), C.R.S. provides in pertinent part for penalties of up to $500 per day if respondent "violates any provision of articles 40 to 47 of this title, or does any act prohibited thereby, or fails or refuses to perform any duty lawfully enjoined within the time prescribed by the director or panel, for which no penalty has been specifically provided, or fails, neglects, or refuses to obey any lawful order made by the director or panel . . ." "Order" is defined in section 8-40-201(15), C.R.S., "'Order' means and includes any decision, finding and award, direction, rule, regulation, or other determination arrived at by the director or an administrative law judge."

2. Under section 8-43-304(1), claimant must first prove that the disputed conduct constituted a violation of statute, rule, or order. *Allison v. Industrial Claim Appeals Office*, 916 P.2d 623 (Colo. App. 1995); *Villa v. Wayne Gomez Demolition & Excavating, Inc.*, W.C. No. 4-236-951 (ICAO, January 7, 1997). Second, if the respondent committed a vio-

lation, penalties may be imposed only if the respondent's actions were not reasonable under an objective standard. *Pioneers Hospital of Rio Blanco County v. Industrial Claim Appeals* Office, 114 P.3d 97 (Colo. App. 2005); *Jiminez v. Industrial Claim Appeals Office*, 107 P.3d 965 (Colo. App. 2003); *Pueblo School District No. 70 v. Toth*, 924 P.2d 1094 (Colo. App. 1996). The standard is "an objective standard measured by the reasonableness of the insurer's action and does not require knowledge that the conduct was unreasonable." *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office*, 907 P.2d 676, (Colo.App., 1995).

3. OACRP 15 provides:

> After a response to an application is filed, the application may not be withdrawn and the hearing may not be vacated except upon the agreement of all parties or upon the order of a judge. If the parties agree to the withdrawal of the application the applicant must promptly notify the OAC of the agreement to vacate the hearing. Notification shall be made by letter, facsimile or telephone.

As found, the insurer's attorney committed an unreasonable violation of OACRP 15 by filing the cancellation form with the check in the box to verify that all parties agreed.

4. ICAO determined that the unreasonable violation of OACRP 15 was subject to a penalty pursuant to section 8-43-304, C.R.S., and remanded for a determination of the amount of the penalty.

5. Section 8-43-304, C.R.S. requires imposition of a penalty of at least one cent and up to $500 for the insurer's unreasonable one-time violation of the rule. *Marple v. Saint Joseph Hospital*, W.C. No. 3-966-344 (Industrial Claim Appeals Office, September 15, 1995)(decided under predecessor section 8-53-116). All of the circumstances must be considered in determining the amount. The amount of the penalty should be sufficient to dissuade a violator from future violations, but should not be constitutionally excessive or grossly disproportionate to the violation found. The ALJ should consider the reprehensibility of the conduct involved, the harm to the non-violating party and the difference between the amount of the penalty and civil damages that could be imposed in comparable cases. *Associated Business Products v. Industrial Claim Appeals Office,* 126 P.3d 323 (Colo.App. 2005). As found, the violation by respondents should be subject to a penalty of $100. Seventy-five percent (75%) of the penalty is payable to claimant as the aggrieved party and twenty-five percent (25%) is payable to the Subsequent Injury Fund.

ORDER

It is therefore ordered that:

The insurer shall pay a penalty in the amount of $75 to claimant and $25 to the Subsequent Injury Fund.

All matters not determined herein are reserved for future determination.

DATED: January 7, 2010

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-761-187

PROCEDURAL STATUS

An administrative hearing was held on April 23, 2009, before the undersigned ALJ. Following the hearing, which was submitted for determination on stipulated facts, a Summary order was entered, on June 10, 2009, and following a request from Respondents, Specific Findings of Fact, Conclusions of Law and Order were entered, on June 25, 2009. On July 8, 2009, a Petition for Review of the Specific Findings of Fact of the ALJ was filed. On October 14, 2009, ICAO entered an Order affirming in part, setting aside in part and remanding the Order to the ALJ for further proceedings.

The October 14, 2009, ICAO order directed the ALJ to determine whether the employer made a valid written offer of modified employment within the meaning of Section 8-42-105(3)(d)(I), C.R.S. If the ALJ finds there was such an offer, the ALJ shall determine whether Claimant refused to begin the employment, which terminates Claimant's entitlement to TTD under Section 8-42-105(3)(d)(I), in accordance with *Laurel Manor Care Center v. ICAO*, 964 P.2d 589 (Colo. App. 1998).

Consistent with a suggestion from the Industrial Claims Appeal Panel, contained in the October 14, 2009, Remand Order, the ALJ entered an Order to Show Cause on December 3, 2009, directing the parties to advise the ALJ whether this matter should be dismissed as moot. Respondents responded to the Order to Show Cause requesting that the ALJ enter an Order on Remand because Respondents contend the issue is not moot and should not be dismissed. Claimant did not respond to the Order to Show Cause.

ISSUES

The issue for consideration on remand is whether the Employer made a valid written offer of modified employment within the meaning of Section 8-42-105(3)(d)(I), C.R.S. If the ALJ finds there was such an offer, the issue is whether Claimant refused

to begin the employment, which terminates Claimant's entitlement to TTD under Section 8-42-105(3)(d)(I), in accordance with *Laurel Manor Care Center v. ICAO*, *supra*.

FINDINGS OF FACT

1. Claimant suffered a June 2, 2008, injury to her left foot. Claimant received TTD. Claimant received medical treatment for her injury and Dr. Holthouser was her attending physician.

2. On September 16, 2008, Dr. Holthouser returned Claimant to modified employment. The doctor imposed restrictions including, "no carrying, no pushing or pulling, minimal walking, minimal standing, no weightbearing right [sic] foot should avoid crawling, kneeling, squatting and climbing. She may use crutches and scooter for mobilization."

3. Based on the parties stipulated facts, the Employer sent Claimant letters dated October 10, 16, and 22, 2008, offering modified employment and, on October 30, 2008, terminating Claimant's employment.

4. On October 10, 2008, the Employer wrote Claimant a letter in which the Director of Human Resources states,

> We received the report from your September 16, 2008 appointment with Dr. Holthouser, which released you back to work with certain restrictions beginning September 16, 2008. To date, you have not shown up for work or contacted us. In fact, we attempted to contact you on October 8 and October 9, 2008 and left messages for you at both your home phone number and cell phone number.

The letter advised Claimant that she was expected to return to work on October 13, 2008. The October 10, 2008, letter did not contain a description of the modify duty position that Claimant was offered by the Employer.

5. On October 16, 2008, the Employer's Director of Human Resources wrote Claimant advising her that she had received Dr. Holthouser's medical report dated October 13, 2008, in which Claimant was released to work with restrictions. The letter noted that Dr. Holthouser's report permitted Claimant to work from home, if permitted by the Employer. The Employer's Director of Human Resources in the letter of October 16, 2008, advised Claimant that she was permitted to work from home on Tuesdays and Thursdays and that she was expected to appear for work at the job site on Monday, Wednesday, and Friday. The letter advised that the work at home arrangement was only temporary and that the Employer could modify or terminate the arrangement depending on the needs of the Employer. Claimant was directed to return to work on October 20, 2008. The October 16, 2008, letter did not contain a description of the modified duty position offer to Claimant by the Employer.

6. On October 22, 2008, the Employer's Director of Human Resources wrote to Claimant. The letter recited the information contained in the previous letters of October 10, and 16, 2008. The letter referred to the Employer's attempts to communicate with Claimant by telephone. The letter directed Claimant to return to work by October 27, 2008, or she would be deemed to have resigned on October 30, 2008. The October 22, 2008, letter did not contain a description of the modified duty position offer to Claimant by the Employer.

7. The parties stipulated that Claimant did not personally respond to the letters of October 10, 16, or 22, 2008; however, Claimant did respond to the letters through her attorney, on October 24, 2008, when Claimant's attorney wrote the Insurer's adjuster handling the claim with a copy of the letter to the employer and, on November 25, 2008, when Claimant's attorney wrote the Respondents' attorney.

8. Based on the Employer's communications to Claimant by letters dated October 10, 16, and 22, 2008, demanding Claimant's returned to work, it cannot be concluded that Claimant was offered a modified duty position with the Employer within her restrictions as established by Dr. Holthouser. The letters, dated October 10, 16, and 22, 2008, fail to provide information about the modified duties assigned to Claimant upon her return to work. Without information about the duties assigned Claimant, it cannot be concluded that an offer of modified employment was made such that Claimant was under an obligation to return to work.

9. While the Employer's letters of September 16 and 22, 2008, give Claimant the option of working at home two days per week, the letters do not address Dr. Holthouser's restrictions of no carrying, no pushing or pulling, minimal walking, minimal standing, no weight bearing left foot, and should avoid crawling, kneeling, squatting, and climbing. Dr. Holthouser also directed that Claimant may use crutches and scooter for mobilization, but the Employer in its offer of modified employment did not address these limitations.

10. It is found that TTD could not be terminated under Section 8-42-105(3)(d)(I), C.R.S. because an offer of employment within Claimant's restrictions was not made by the Employer.

CONCLUSIONS OF LAW

On remand, the ICAO directed the ALJ to make findings regarding the issue whether an offer of employment within Claimant's restriction was made to Claimant by the Employer.

The applicable law provides that once Respondents admit liability for TTD, payments must continue until terminated in accordance with Section 8-42-105(3)(a)-(d), C.R.S. *Colorado Compensation Insurance Authority v. Industrial Claim* Appeals *Office*,

18 P.3d 790 (Colo. App. 2000). Section 8-42-105(3)(d)(I), C.R.S. provides that temporary disability benefits terminate when

> the attending physician gives the claimant a written release to return to modified employment, such employment is offered to the employee in writing, and the employee fails to begin such employment.

The evidence presented in this case established that Claimant was never offered a position with the Employer within her restriction. The letter sent to Claimant by the Employer in October 2008, clearly, directs Claimant to return to work in light of Dr. Holthouser's September 16, 2008, release to modified duty. But, these letters do not reflect what position and what duties she would be assigned such that it can be determined that the duties assigned are within her restrictions. Therefore, under Section 8-42-105(3)(d)(I), the respondents cannot terminate TTD. Since Respondents failed to prove an offer of modified employment was made to Claimant, an analysis of the case under *Laurel Manor Care Center v. Industrial Claim Appeals Office*, supra, is not required.

ORDER

It is therefore ordered that:

1. Respondents cannot terminate TTD under Section 8-42-105(3)(d)(I), C.R.S. because it was not established that the Employer made a valid offer of employment that was within Claimant's work restrictions.

All matters not determined herein are reserved for future determination.

DATED: January 7, 2010

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
W.C. No. 4-798-028

FULL FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

ISSUE

The sole issue to be determined by this decision concerns whether the Claimant was an employee of the Respondent or was an independent contractor on the date of injury. The hearing was slated for a full contest but was bifurcated and proceeded only

on the issue of the Claimant's employment status, with the remaining issues reserved for further consideration should the Claimant be deemed an employee.

FINDINGS OF FACT

Based on the evidence presented at hearing, the ALJ makes the following Findings of Fact:

1. The Claimant alleges that he sustained an injury while in the course and scope of his employment with the Respondent on November 14, 2008. The Respondent alleges that the Claimant was not an employee but an independent contractor and, therefore, not entitled to benefits under the Workers' Compensation Act.

2. The Respondent is in the business of data installation for commercial businesses (hereinafter "customers"). This involves installing low-voltage cables, data and cameras in stores around the country. The jobs are often performed outside of the State of Colorado.

3. At the time of the alleged injury, the Claimant was performing installation services for the Respondent at Hurricane, Utah.

4. The Claimant performed installation services for the Respondent on several jobs over a nearly one-year span from July 2008 to May 2009. The Claimant was paid by the job at a fixed price that was negotiated between him and the Respondent prior to undertaking a job. The Claimant was paid by checks made out to the Claimant personally and not to a business name. The Claimant did not dispute this method of being paid.

5. The Respondent reported the Claimant's 2008 yearly earnings on an IRS form 1099-MISC. All of the Claimant's earnings from the Respondent are found in block 7 of the 1099 form, designated as "non-employee compensation." The ALJ takes administrative notice of the fact that such a form is ordinarily used for individuals who do not work for regular wages, within the common meaning of "wages." The Claimant had no plausible explanation why he received "non-employee compensation" when his theory is that he as an "employee" of the Respondent.

6. On his IRS form 1040 Individual Income Tax Return for 2008, the Claimant listed his (and his wife's) earnings under line 12, as "business income." He also claimed capital losses under line 13. (Respondent's Ex. C, p. 1). The Claimant also admitted to being liable for self-employment tax, reporting the amount on line 57 of form 1040. (Respondent's Ex. C, p. 2). The ALJ infers and finds that this method of dealing with his 2008 income severely compromises the Claimant's credibility when he claims that he was an "employee" as opposed to an independent contractor." The Claimant had no

plausible explanation for declaring his income as "business income" when his theory is that he was an "employee." The ALJ infers and finds that "employees" ordinarily declare their income on line 7 of Form 1040, designated "wages, salaries, tips…." Claimant declared $111.00 on line 7 of his 2008 Form 1040 Tax Return.

7. The Claimant was expected to provide his own transportation to the various job sites and he was not compensated or reimbursed for his vehicle expenses. Transportation expenses were factored into the negotiated price of the contract. Every once in a while, he would hitch a ride with one of the Respondent's representatives to save money.

8. The Claimant and the Respondent's representative, James Cullen Reilly, both stated that the Claimant was not required to work exclusively for the Employer. Given the intense nature of each job, the time constraints mandated by the customer, and the fact that most jobs were not conducted locally, it was generally impractical for the Claimant to perform services for another contractor at the same time. For example, the job in Hurricane, Utah was to last two days. The Respondent informed the Claimant that he was free to work other jobs with other contractors at any time. The Claimant disputed this because it was impractical to work for other companies during an intense job out-of-town.

9. The Claimant was not maintained as an employee but was contacted when a job was available. The Claimant was free to accept or decline work, and the Respondent was free to offer work to the Claimant or another service provider.

10. The Claimant performed similar data installation services for another contractor immediately prior to taking on jobs with the Respondent. He voluntarily stopped performing services for the Respondent in May 2009 and began performing similar services for another contractor.

11. The Claimant provided his own tools, primarily consisting of hand tools carried on a tool belt. The Respondent provided an expensive tester, necessary to verify that the installation was installed to the customer's specifications. The Respondent would sometimes provide ladders, a toner for tracing lines, and a monitor.

12. The Respondent did not establish a quality standard for the Claimant but the resulting product was expected to comply with the customer's specifications. The Respondent did not oversee the actual work or instruct the Claimant as to how the work would be performed. The Claimant disputed this without furnishing specifics as to what he disputed. Indeed, Reilly indicated that the customer, if anyone, established the quality standard.

13. The Respondent did not train the Claimant who was experienced in data installation prior to performing jobs for the Respondent. Claimant did not know

how to perform some functions of the job and Respondent showed him how to do the limited number of functions that Claimant did not know how to do.

14. The Respondent did not dictate the time of performance, but the customer generally provided a completion schedule and often established work hours to minimize business interruptions to the customer. Because of the customer's requirements, the Claimant and the crew often met in the hotel lobby to travel with the Respondent to the customer's location. At the end of the day, Claimant and the crew returned to the hotel together.

15. There was no commingling of the business operations of the Claimant and the Respondent

16. There was no written independent contractor agreement, but the ALJ finds that there was a verbal independent contractor agreement, entered into before each job was to commence.

17. The Claimant was customarily engaged in an independent occupation and was free from the direction and control of the Respondent. The Claimant was free to come and go as he pleased between jobs and worked in the same occupation for other contractors both before and after performing jobs with the Respondent. Although the Respondent did not meet all nine criteria established at § 8-40-202(2)(b)(II), C.R.S. (2009), Respondent successfully satisfied the bulk of the criteria and the criteria deemed most critical by the ALJ to carry its burden of proof. Accordingly, the ALJ finds that the Claimant was an independent contractor on the date of injury.

18. The Respondent has proven, by a preponderance of the evidence, that the Claimant was not an "employee" but an "independent contractor."

CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the ALJ makes the following Conclusions of Law:

Credibility

a. In deciding whether an injured worker has met the burden of proof, the ALJ is empowered "to resolve conflicts in the evidence, make credibility determinations, determine the weight to be accorded to expert testimony, and draw plausible inferences from the evidence." *See Kroupa v. Industrial Claim Appeals Office*, 53 P.3d 1192, 1197 (Colo. App. 2002); *Penasquitos Village, Inc. v. NLRB*, 565 F.2d 1074 (9th Cir. 1977). The fact finder should consider, among other things, the consistency or inconsistency of a witness' testimony and/or actions; the reasonableness or unreasonableness (probability or improbability) of a witness' testimony and/or actions; the motives of a witness; whether the testimony has been contradicted; and, bias, prejudice or interest. *See Pru-*

dential ins. Co. v. Cline, 98 Colo. 275, 57 P. 2d 1205 (1936); CJI, Civil, 3:16 (2005). As found, the Claimant's actions in declaring all of his income as "business income" on his 1040 Form and declaring $111.00 in wages renders his thrust that he was an "employee" lacking in credibility. Indeed, the ALJ finds Claimant's proposition that he was an "employee" of the Respondent incredible under the circumstances. On the other hand, James Cullen Reilly's (Respondent's representative) testimony is entirely consistent with Claimant being an "independent contractor." The ALJ resolves the conflict in the testimony/theory in favor of Reilly and against the Claimant.

Independent Contractor vs. Employee

b. An individual who performs services for another is an employee "unless such individual is free from control and direction in the performance of the service, both under the contract for performance of service and in fact and such individual is customarily engaged in an independent trade, occupation, profession, or business related to the service performed." § 8-40-202(2)(a), C.R.S. (2009). Here, the evidence demonstrates that on the date of injury the Claimant was free from the control and direction of the Employer and the Claimant was customarily engaged in an independent occupation.

c. In determining whether an "employee" is an independent contractor, the ALJ is guided by the nine criteria contained in § 8-40-202(2)(b)(II), C.R.S. (2009). It is not necessary to satisfy each of the criteria to demonstrate that an individual is an independent contractor. *Nelson v. Industrial Claim Appeals Office*, 981 P.2d 210, 212 (Colo. App.1998). Because "independent contractor" status is an exception to the general coverage requirements of the Workers' Compensation Act, Respondent has the burden to prove, by a preponderance of the evidence that the Claimant was an independent contractor. § 8-40-202(2)(b)(I), C.R.S. (2009); *Frank C. Klein & Company v. Colorado Compensation Insurance Authority*, 859 P.2d 323, 328 (Colo. App. 1993). As found, Respondent satisfied its burden of establishing that the Claimant was an "independent contractor" at the time of his injury.

The Nine Criteria of § 8-40-202(2)(b)(II)(A)-(H), C.R.S. (2009)

d. The nine criteria are:

(1) Require the individual to work exclusively for the person for whom services are performed; except that the individual may choose to work exclusively for such person for a finite period of time specified in the document

As a practical matter it may have been difficult for the Claimant to perform work for another contractor while on an out-of-state job for which the customer had tight constraints. But there was no legal constraint requiring the Claimant to work exclusively for

the Respondent and the Claimant was informed that he was free to work for other contractors.

(2) Establish a quality standard for the individual; except that the person may provide plans and specifications regarding the work but cannot oversee the actual work or instruct the individual as to how the work will be performed

The Respondent did not establish a quality standard for the Claimant but the resulting product was expected to comply with the customer's specifications. The Respondent did not oversee the actual work or instruct the Claimant as to how the work would be performed. *See In re Pulsifer v. Pueblo Professional Contractors, Inc.,* 161 P.3d 656 (Colo. 2007).

(3) Pay a salary or at an hourly rate instead of at a fixed or contract rate

The Claimant was paid by the job at a fixed price that was negotiated between him and the Respondent prior to undertaking a job.

(4) Terminate the work of the service provider during the contract period unless such service provider violates the terms of the contract or fails to produce a result that meets the specifications of the contract

The Claimant could not be fired from the payroll of the Employer in the sense that an employee could be fired. He was not maintained as an employee but was contacted when a job was available. The Claimant was free to accept or decline work, and the Respondent was free to offer work to the Claimant or another service provider.

(5) Provide more than minimal training for the individual

The Respondent did not train the Claimant who was experienced in data installation prior to performing jobs for the Respondent. Respondent only showed Claimant how to do some things unique to the job at hand.

(6) Provide tools or benefits to the individual; except that materials and equipment may be supplied

The Claimant provided his own tools, primarily consisting of hand tools carried on a tool belt. The Respondent sometimes supplied equipment such as an expensive tester, ladders, a toner for tracing lines, and a monitor.

(7) Dictate the time of performance; except that a completion schedule and a range of negotiated and mutually agreeable work hours may be established

The Respondent did not dictate the time of performance. The customer imposed certain work hour requirements in a manner analogous to a homeowner require that a roofer not work between 10:00 PM at night and 6:00 AM the next morning.

(8) Pay the service provider personally instead of making checks payable to the trade or business name of such service provider

The Claimant was paid by checks made out to the Claimant personally and not to a business name.

(9) Combine the business operations of the person for whom service is provided in any way with the business operations of the service provider instead of maintaining all such operations separately and distinctly

There was no commingling of the business operations of the Claimant and the Respondent.

e. As found, the Claimant was customarily engaged in an independent occupation and was free from the direction and control of the Respondent. The Claimant was free to come and go as he pleased between jobs and worked in the same occupation for other contractors both before and after performing jobs with the Respondent. Although the Respondent did not meet all of the nine criteria established at § 8-40-202(2)(b)(II), C.R.S. (2009), it successfully satisfied the bulk of the criteria and the criteria deemed most critical by the ALJ to carry its burden of proof. Accordingly, the ALJ concludes that the Claimant was an independent contractor on the date of injury and is not entitled to workers' compensation benefits.

Burden of Proof

f. The injured worker has the burden of proof, by a preponderance of the evidence, of establishing entitlement to benefits. §§ 8-43-201 and 8-43-210, C.R.S. (2008). *See City of Boulder v. Streeb,* 706 P. 2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P. 3d 844 (Colo. App. 2000); *Lutz v. Industrial Claim Appeals Office,* 24 P. 3d 29 (Colo. App. 2000). Also, the burden of proof is generally placed on the party asserting the affirmative of a proposition. *Cowin & Co. v. Medina,* 860 P. 2d 535 (Colo. App. 1992). In this case, Respondent asserted that the Claimant was an "independent contractor" an not an "employee." A "preponderance of the evidence" is that quantum of evidence that makes a fact, or facts, more reasonably probable, or improbable, than not. *Page v. Clark,* 197 Colo. 306, 592 P. 2d 792 (1979); *People v. M.A.,* 104 P. 3d 273 (Colo. App. 2004); *Hoster v. Weld County Bi-Products, Inc.,* W.C. No. 4-483-341 [Industrial Claim Appeals Office (ICAO), March 20, 2002]. *Also see Ortiz v. Principi,* 274 F.3d 1361 (D.C. Cir. 2001). As found, Respondent sustained its burden of proof.

ORDER

IT IS, THEREFORE, ORDERED THAT:

Any and all claims for workers' compensation benefits are hereby denied and dismissed.

DATED this_____day of January 2010.

EDWIN L. FELTER, JR.
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-793-962

ISSUES

1. Whether Claimant was an employee or independent contractor at the time of his injury on May 10, 2009.

2. Whether the right to select a primary care physician passed to Claimant when Respondent failed to offer Claimant a choice of physicians pursuant to W.C.R.P. Rule 8-2. In the alternative, after Respondent authorized Jeff Wunder, M.D. to treat Claimant, did the right to choose his primary physician revert to Claimant when Respondent refused to pay for treatment recommended by Dr. Wunder.

3. Temporary total disability benefits from May 10, 2009 and continuing.

STIPULATIONS

The parties stipulate to the following:

1. Claimant's average weekly wage is $504.45 and his TTD rate is thus $336.30.

2. Respondents are entitled to offset $1000.00 against any TTD or TPD due and owing.

FINDINGS OF FACT

1. On May 10, 2009 Claimant was driving a truck owned by Employer. While driving Employer's truck outside of Atlanta, Georgia, Claimant sustained serious injuries when he was involved in an accident. According to Claimant, the brakes in his truck failed. The truck that Claimant was driving had just been worked on and Claimant had picked the truck up from a repair shop before leaving for the trip to Georgia. Claimant reported mechanical problems with the truck to David Stark, owner of Employer, the day before the accident happened.

2. Claimant was transported by ambulance to the hospital, AnMed Health in South Carolina. Among other things, the Claimant was admitted for skull fractures and a head injury. An initial CT scan of the Claimant's head noted extensive fractures involving the nasal bone, the medial left orbital wall, and also fractures of the left frontal bone extending into the orbital roof with a suggestion of subdural hematoma. By May 12, 2009 a CAT scan of Claimant's head revealed "... air in the subdural space as well as mild subarachnoid blood and a small hypodense area in the left posterior, frontoparietal region." (Exhibit 2, page 5)

3. Claimant was discharged from AnMed on May 15, 2009. Along with facial lacerations, facial fractures, neck and right shoulder pain, Claimant's discharge diagnoses included closed head injury, frontal node fracture, improving pneumocephalus and a right optic nerve contusion.

4. David Stark and his wife, Cindy Stark, own Employer. Employer provides commercial transportation of goods for hauling by truck. Employer started as a "brokerage" approximately ten years ago and later became an "asset-based" company when it acquired trucks and drivers from a company Employer bought out. David Stark admitted that the term "asset-based" meant that Employer obtained trucks to haul goods.

5. According to David Stark, he and his wife Cindy consider themselves to be Employer's "operations side" while drivers are the "transport side." David Stark also admitted that without drivers none of the goods hauled by Employer could be hauled.

6. Employer is responsible for complying with all local, state and federal regulations governing its business including the D.O.T. (Department of Transportation) and the P.U.C (Public Utilities Commission). All the documents Employer provided to Claimant before hiring him are documents Employer is required to provide by the D.O.T. Several of those documents were admitted into evidence. As noted, Employer is subject to the Federal Motor Carrier Safety Act ("FMCSA"). Employer is bound by and abides by FMCSA rules and regulations in the hiring of its drivers and in the use and fielding of the trucks Employer owns. (Claimant's Exhibit's 26 - 31)

7. Claimant began driving for Employer in July of 2008. Claimant first learned of Employer when he saw a sign advertising for drivers on the side of the road outside of Employer's headquarters. David Stark did not dispute Claimant's assertion that Employer had posted a sign by its headquarters soliciting drivers.

8. Among the paperwork provided to him by Employer before he began driving for them in July of 2008, Claimant filled out a document entitled "Employment Application for Commercial Drivers." He completed documentation relating to his work history, additional paperwork and also underwent a comprehensive medical examination, urinalysis and other testing as required by Employer. These steps were taken, as noted above, pursuant to Employer's obligation to abide by local, state, and Federal statutes and regulations, including the FMCSA. Claimant did not fill out any paperwork indicating that he was an independent contractor. Claimant was not provided with any paperwork to review that indicated he was an independent contractor. David Stark agreed that Claimant had not been provided with any paperwork identifying him as an Independent contractor. Claimant believed he was a commercial driver working for Employer.

9. Claimant testified that he was not told he would be an independent contractor when he was hired. (Hearing 2:32:50) David Stark testified that he did tell Claimant he was an independent contractor. (Hearing 3:36:48) Claimant was not a salaried employee and was not paid by the hour. Claimant was not provided any benefits other than payment at the rate of thirty-three cents per mile.

10. Claimant was not offered workers' compensation insurance through Pinnacol and was not offered coverage of any other type, whether such coverage was similar to coverage offered by Pinnacol or otherwise. (Hearing, 1:58.21) David Stark admitted that he never offered workers' compensation coverage to Claimant. (Hearing 3:38:15) On direct, when asked if he had ever mentioned "C.C.I.A., Pinnacol," or "any other insurance company" to Claimant, David Stark admitted that he had not. (Hearing 3:38:25)

11. Employer issued checks to Claimant in Claimant's name.

12. Before he began working for Employer, Claimant had injured his shoulders and knees while driving for another employer. Claimant was placed at MMI and released to full duty by his treatment provider before going to work for Employer. (Claimant's Exhibit 1)

13. Claimant was hired by Employer to haul meat from Colorado to places outside of Colorado. According to Claimant, he was informed where he had to go in order to pick up a load and also where that load had to be delivered. After the load was delivered to its appointed destination, Claimant was then informed by Employer where to go to pick up a load for the return to Colorado (and where that load needed to be dropped off.) Employer's dispatcher told Claimant where to go and when to get there.

14. Before he left to deliver a load, Employer provided Claimant with $200.00 in cash to pay "lumpers." "Lumpers" are workers present at the point of delivery so that the meat (goods) Claimant had hauled could be unloaded. Claimant never paid lumpers out of his own pocket. If the cost for lumpers exceeded $200.00, Claimant had to

call David or Cindy Stark for approval. Claimant did not unload the good he had hauled. Respondent did not dispute Claimant's testimony regarding the use and payment of lumpers.

15. Claimant was not provided with any handbook from Employer. Claimant did not receive any written company rules or regulations from Employer other than those pertaining to state, local or federal rules and regulations. Claimant did not receive any training from Employer.

16. It was undisputed that Employer owned the truck Claimant was driving and that Employer also owned several other trucks its drivers used. Employer paid for maintenance on these trucks. It paid for repairs when they broke. It paid for the gas they used and for tows, as necessary. It paid for the insurance covering them. It paid for the license plates they bore and for every other tag, sticker or permit required by local, state and Federal authorities including the D.O.T. and the P.U.C. David Stark also testified that Drivers are a cost of doing business and that the more Employer spent on such things the less Employer made. (Hearing 3:53:20 and continuing on roughly through 3:55:30). Claimant never paid for anything related to use of Employer's truck.

17. According to Claimant, Employer provided their drivers with directions to their destinations. (Hearing 1:59:45) Claimant also believed that drivers were not free to pick or chose the routes they drove to reach those destinations. (Hearing 1:59:51) In contrast, according to David Stark, Employer never so much as even suggested a route to any of its drivers. (Hearing 3:57:20) David Stark did admit that when its drivers drove fewer miles, Employer made more money. (Hearing 3:57:55)

18. Claimant regularly received pick-up and delivery deadlines from Employer and was required to meet those deadlines. David Stark testified that deadlines were imposed by Employer's customers, not Employer. (Hearing 3:56:23) Claimant did not enter into any contracts with Employer's customers. Employer was a party to the contracts with its customers and each pick up and each delivery constituted a distinct contract. If Employer's drivers did not meet its customers' deadlines, then Employer could lose customers.

19. Employer's trucks bear signs advertising the company's name.

20. Claimant testified he could not drive for anyone other than Employer. Claimant testified that he had no time to work for another company due to a DOT rule preventing drivers from driving more than 70 hours a week, and that he had to be at Employer's "beck and call." (Hearing 2:58:40) Claimant testified he could not refuse loads. Claimant testified that he would have been terminated for refusing loads. (Hearing, 2:54:40) Claimant also testified that he was not free to pick and choose among loads and that he was not free to pick and choose destinations. (Hearing 2:00:01 through 2:00:43.) David Stark testified that drivers were not prohibited from working for others, that they could refuse loads at will, and that they wouldn't be fired just for refusing a load. (Hearing 3:20:56 through 3:20:49) However, David Stark also testified that a

driver could be excused from making a trip if, for example, he had a medical emergency. (Hearing 4:03:31) If refusing loads wasn't a problem for Employer, then why would any driver need to provide Employer with an excuse, whether medical emergency or otherwise. For this reason, it is found more probably true than not that Claimant was required to haul the loads given to him by Employer absent a medical or other emergency excuse.

21. Though Employer paid Claimant in his name, taxes were not taken out of Claimant's checks and Claimant was provided with an IRS form 1099. Claimant testified that David Stark told him it would be "easier" to conduct business that way and that he would get paid more money that way. David Stark didn't dispute Claimant's testimony. While driving for other employers, there were times when Claimant was paid as an employee and had taxes taken out and there were times when he received a 1099 and was responsible for his own taxes. Claimant's Exhibit No. 38 was his tax return for the year 2008. On it, Claimant's tax preparer listed Claimant's principal business as "Trucking/delivery" and listed the business name as "LogiGroup, Inc. Respondent introduced Claimant's tax returns from 2006 and 2007. Suffice to say, in addition to taxed income from employers, Claimant's 2006 and/or 2007 records show untaxed income that Claimant earned while trucking and show that part of the income Claimant received in those years was from a trucking business in which Claimant essentially was the proprietor. It was established at hearing, however, that Claimant had once owned his own truck that he used for driving (in 2006, for example) but that by the time Claimant went to work for Employer in 2008, Claimant no longer owned a truck. (Hearing 3:11:30) That Claimant may have worked for himself and not had taxes taken out when he owned his own truck and drove it for others is not evidence that Claimant wasn't an employee of Employer when he drove one of their trucks in 2008 and 2009.

22. Claimant's driver's license was suspended on November 29, 2008. (Claimant's Exhibit No. 35.) Claimant stopped working for Employer after his license was suspended. The parties stipulated that, in the year 2008, Claimant last worked for Employer on December 13. Claimant returned to work for Employer in May of 2009. It is undisputed that Employer did not have Claimant fill out any new paperwork in May of 2009.

23. On May 8, 2009 Claimant contacted Employer looking for work. He spoke with Cindy Stark and discussed the prospect of driving locally. Later that day he discussed the issue with Charlotte – Employer's dispatcher – and was told that he had been assigned to haul a load of meat to Georgia. Claimant thereafter went to Employer's headquarters and received assurances from the Starks that he would be covered by insurance. (Hearing 1:55:42 and continuing) According to David Stark, the only insurance that Claimant would have been provided with was liability insurance covering the truck.

24. Employer never provided Claimant with the names of any physicians that he could see if he was injured while driving. Employer did not provide workers compensation coverage for any of its drivers including Claimant.

25. David Stark first learned of Claimant's May 10, 2009 accident when he was contacted by the Georgia State Highway Patrol on the day of the accident. During that initial contact, he learned that Claimant had sustained injuries and was en route to a hospital. David Stark and/or his wife Cindy and/or Employer's dispatcher, Charlotte, were frequently in contact with Claimant and/or Claimant's ex-wife while Claimant remained in ICU at the Hospital in Georgia.

26. Claimant was transported to Colorado by another Employer driver after Claimant was discharged from the hospital.

27. When Claimant was discharged from the hospital, he was instructed to see a physician when he returned to Colorado. Claimant scheduled an appointment with Dr. Frank Morgan, who first saw Claimant on May 18, 2009. On May 18, 2009, Claimant also saw Charles Johnson, D.D.S., for evaluation and treatment of the dental injuries he sustained in the May 10, 2009 accident. Dr. Frank Morgan referred Claimant to an ophthalmologist, Dr. Matthew Uyemura, who first saw Claimant on May 19, 2009. Dr. Uyemura determined that Claimant had sustained a traumatic optic neuropathy in the right eye and opined that he would not regain his sight. Dr. Uyemura referred Claimant to the Aschziger Vision Center and Claimant was evaluated there on May 26, 2009. Dr. Morgan also referred Claimant to Dr. Hans Coester, a neurosurgeon, who evaluated Claimant on June 5, 2009 and ordered diagnostic studies (including a brain MRI that revealed that Claimant had sustained inferior frontal contusions "... with probable interhemispheric subdural and probable subtle area of contusion to the corpus callosum, slightly to the left side." Dr. Coester noted Claimant's ongoing complaints of headache, dizziness, cognitive problems and also pain the neck and right shoulder. Dr. Coester also referred Claimant to Dr. Reichhardt for further evaluation.

28. On June 18, 2009, Employer designated Dr. Wunder as the authorized treating physician. Claimant's first appointment with Dr. Wunder was on July 17, 2009. Dr. Wunder provided treatment including medications, bilateral EMG studies and a short a course of physical therapy. The EMG studies were performed and Claimant participated in six physical therapy visits at Momentum Physical Therapy. When Claimant returned to Dr. Wunder on August 14, 2009 the doctor noted that Claimant continued to have head, neck and shoulder problems. Dr. Wunder noted: "This is a difficult situation. Apparently, this case is being litigated, and there is significant limitation in the amount of evaluation and treatment that he can receive. At this point, the only thing I can offer him is medication management." (Claimant's Exhibit No. 6) Claimant saw Dr. Wunder for a final visit in September of 2009. Dr. Wunder noted that Claimant continued to have the same complaints as before, along with feelings of helplessness and depression. Because authorization for treatment was being denied, Dr. Wunder stated in his report: "I am not able to accomplish anything as far as further evaluation or treatment." (Claimant's Exhibit No. 7)

29. At the hearing in this matter, Respondent's counsel admitted that authorization for medical treatment was "held in abeyance" pending the outcome of litigation. Medical treatment with Dr. Wunder was denied for non-medical reasons.

30. Claimant underwent an independent medical evaluation with Dr. L. Barton Goldman on October 19, 2009. Dr. Goldman diagnosed Claimant with the following accident related conditions: (1) head injury with nasal and left orbital wall fractures, complicated by pneumocephalus; (2) right optic nerve neuropathy and agnosia with subjective complaints of tinnitus; (3) mild residual cognitive dysfunction affecting executive functioning which could also be impacted by anxiety and depression; (4) probable chronic cervicalgia and facet dysfunction; (5) sleep dysfunction; (6) fractured teeth; (7) pseudo right thoracic outlet syndrome with myogenic origin; (8) deconditioning; and (9) mixed tension and vascular headaches. Other conditions were noted but not felt to be directly related to the accident.

31. Dr. Goldman recommended treatment for these conditions including adjustment counseling, medications, audiologic and possible ENT evaluations, physical therapy, massage therapy, and such other treatment as may be necessary depending on Claimant's progress.

32. Claimant has not worked since May 10, 2009. Employer has not offered Claimant any work since that time. Physicians who have seen him have not released him to work. Mack Green, Ed.D., A.B.N., performed neuropsychological testing on Claimant in October of 2009. Among other diagnoses, he determined that Claimant had "prominent executive functioning difficulties" stemming from the head injury along with moderate emotional distress." (Claimant's Exhibit No. 8) Claimant experiences headaches, pain in his neck and shoulder, and cognitive problems including memory loss and information processing. Claimant is also blind in his right eye and has lost his senses of taste and smell.

CONCLUSIONS OF LAW

1. Claimant bears the burden of proving by a preponderance of the evidence that his injury arose out of and in the course of employment. See City of Boulder v. Streeb, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which lead the trier of fact to conclude that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P.2d 792 (Colo. 1979) An ALJ's factual findings need concern only evidence that is dispositive on the issues involved, the ALJ is not required to address every piece of evidence that might lead to a different conclusion and the ALJ can reject evidence that is contrary to his findings as being unpersuasive. Magnetic Engineering Inc. v. I.C.A.O., 5 P. 3d 385 (Colo. App. 2000).

EMPLOYEE VERSUS INDEPENDENT CONTRACTOR STATUS

2. Claimant has met his burden of proof. Claimant was an employee of Employer at the time of his injury on May 10, 2009.

3. Employer is a carrier and subject to the provisions of Section 8-40-301, C.R.S. Since they failed to comply with the provisions of that statute, by operation of law, Claimant is deemed to be Employer's employee.

4. According to Black's Law Dictionary (Fifth Edition), a "carrier" is an "[i]ndividual or organization engaged in transporting passengers or goods for hire." Black's defines "contract carrier" as "A transportation company that carries, for pay, the goods of certain customers only as contrasted to a common carrier that carries the goods of the public in general." Employer described its business operation as one that "provides commercial transportation of goods for hauling by truck." David Stark testified that Employer began as a "brokerage" and later became "asset-based" when it obtained a fleet of trucks for hauling. David Stark also testified that Employer's "assets" are its trucks and drivers and that it wouldn't make any money without them. Additionally, the evidence showed that Employer's operations are subject to DOT and P.U.C. regulations and that it is subject to the Federal Motor *Carrier* Safety Act.

5. Section 8-40-301(6), C.R.S. provides that "[a]ny person working as a driver with a common or contract carrier as described in this section shall be eligible for and shall be offered workers' compensation insurance coverage by Pinnacol Assurance or similar coverage consistent with the requirements set forth is section 40-11.5-102 (5), C.R.S. The terms "common" and "contract" are not defined therein. In Denver Cleanup Serv., Inc. V. Public Utils. Comm'n, 192 Colo. 537, 539-40, 561 P.2d 1252, 1253 (1977), the Supreme Court defined common carrier as "one which must indiscriminately accept and carry passengers or property between fixed points or over established routes." The Supreme Court opined that the main difference between contract carriers and common carriers was that "a contract carrier has an obligation only to his contract customers and has no obligation to others desiring carriage." *Supra* at 1253.

6. Section 40-11.5-101, C.R.S. states: "Notwithstanding any provisions in article 10 or article11 of this title, motor vehicle carriers and contract motor carriers may use independent contractors." C.R.S. 40-11.5-102 is clearly directed at drivers working as independent contractors for carriers of goods and specifically identifies the procedures that carriers of goods must follow when they enter into leases arrangements or contracts with independent contractors. Pursuant to C.R.S. 40-11.5-102 (5), the lease or contract must provide for coverage under workers' compensation or a private insurance policy that provides similar coverage.

7. Reading C.R.S. 40-11.5-101 & 102 in conjunction with C.R.S. 8-40-301 (5) and (6), it becomes quite clear that the reference to both "common" and "contract" carriers in the Workers' Compensation Act was meant to be inclusive. Those terms are used as originally intended to refer to all companies who haul persons or goods via interstate or intrastate commerce. Companies like Employer who want to employ independent contractors as drivers to conduct their business operations must offer those independ-

ent contractors workers' compensation insurance coverage through Pinnacol or similar coverage through another insurer. When they don't, as happened here, the Claimant is deemed to be an employee. USF Distribution Services, Inc. V. Industrial Claim Appeals Office, 11 P3d. 529 (Colo. App. 2004).

8. David Stark, Employer's owner, testified that he never even mentioned Pinnacol Assurance or any other insurance company after Claimant completed the requisite "Employment Application" and went to work as a driver for Employer. Claimant also testified that he was not offered such insurance. Given that, employee status is conferred upon Claimant by operation of law.

9. Although no lease agreement or independent contractor agreement was submitted into evidence, based upon a complete review of all evidence, it is concluded that Employer is a contract carrier of goods and Claimant was working as a driver for Employer. Employer failed to comply with Section 8-40-301 (6), C.R.S. by failing to offer Claimant workers' compensation insurance coverage through Pinnacol Assurance or similar coverage with another insurance provider. Therefore, Claimant is an employee of Employer.

10. Assuming Section 8-40-301, C.R.S. is not applicable in this matter, an analysis of C.R.S. 8-40-202(2)(b) also establishes that Claimant was an employee.

11. Section 8-40-202(2)(a), C.R.S., provides that an individual performing services for pay for another is deemed to be an employee:

> [U]nless such individual is free from control and direction in the performance of the service, both under the contract for performance of service and in fact and such individual is customarily engaged in an independent trade, occupation, profession, or business related to the service performed.

12. Section 8-40-202(2)(b)(II), C.R.S., sets forth nine factors to balance in determining if the claimant is an employee or an independent contractor. *See Carpet Exchange of Denver, Inc. v. Industrial Claim Appeals Office*, 859 P.2d 278 (Colo. App. 1993). Section 8-40-202(2)(b)(III), C.R.S., provides that the existence of any one of those factors is not conclusive evidence that the individual is an employee. Consequently, the statute does not require satisfaction of all nine criteria in § 8-40-202(2)(b)(II) in order to prove by a preponderance of the evidence that the individual is not an employee. *Nelson v. Industrial Claim Appeals Office,* 981 P.2d 210 (Colo. App. 1998).

13. Subsection 8-40-202(2)(b)(IV), C.R.S. 2006, provides that, a party may use a written document between the parties as proof of an independent contractor relationship. It has already been established that there is no such document in this matter. While Employer provided Claimant with an "Employment Application," there is no writing of any type establishing that Employer ever intended to treat Claimant as an independent contractor.

14. There is great deal of dispute as to whether Claimant was required to work exclusively for Employer. Claimant indicated that he had to be available whenever, that he would be terminated for turning down loads and that, because he couldn't drive more than 70 hours a week, driving for Employer, alone, was a product of the relationship. David Stark testified that he never prohibited drivers from working for others but didn't dispute that drivers can't drive more than 70 hours in a week. David Stark also testified that a driver could be excused from making a trip if, for example, he had a medical emergency. If refusing loads wasn't a problem for Employer, then why would any driver need to provide Employer with an excuse, whether medical emergency or otherwise. It was found more probably true than not that Claimant was required to haul the loads given to him by Employer absent a medical or other emergency excuse.

15. The evidence also established that Employer "imposed" very specific non-negotiable deadlines on its drivers and there was ample evidence to suggest that Employer did exercise control over the routes its drivers took to both pick up and deliver goods. This type of control over the manner and timing of the trips suggests an employment relationship. That Claimant was paid thirty-three cents a mile suggest an independent contractor relationship but that he was paid in his own name suggests an employment relationship. Additionally, Claimant was not engaged in an independent trade or business at the time of his injury. Employer did not provide training. With the exception of food and clothing, Employer provided Claimant with everything he needed to be a driver, which suggests an employment relationship.

16. Employer combined its business operation with the service provided by its drivers. Employer – which "provides commercial transportation of goods for hauling by truck" -- makes all of its money by entering into contracts with its customers. Contracts pursuant to which Employer agrees to move those goods, by truck, from point A to point B. There is nothing else to its operation and without drivers Employer would exist in name only.

17. The ALJ concludes the Claimant proved it is more probably true than not that he was an employee of the Employer because he was not free from control and direction in the performance of services for the Employer, was not engaged in an independent trade or business at the time of his injury, and Employer combined its business operation with the service provided by its drivers.

INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT

18. The claimant must prove by a preponderance of the evidence that his injury was proximately caused by an injury arising out of and in the course of his employment with employer. Section 8-41-301(1)(b) & (c), C.R.S.*; see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). An injury occurs "in the course of" employment where the claimant demonstrates that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The "arising out of "

element is narrower and requires claimant to show a causal connection between the employment and the injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *See Triad Painting Co. v. Blair*, *supra.*

19. As determined in Finding of Fact 1, Claimant sustained multiple injuries when he was involved in an accident on May 10, 2009 while driving Employer's truck in Georgia. Claimant's injuries arose out of and in the course of his employment as a driver with Employer.

MEDICAL BENEFITS

20. Section 8-43-404(5)(a), C.R.S., gives the respondents the right in the first instance to select the authorized treating physician (ATP). Authorization refers to a physician's legal status to treat the industrial injury at the respondents' expense. *Bunch v. Industrial Claim Appeals Office,* 148 P.3d 381 (Colo. App. 2006); *Popke v. Industrial Claim Appeals Office,* 944 P2d. 677 (Colo. App. 1997). Once an ATP has been designated the claimant may not ordinarily change physicians or employ additional physicians without obtaining permission from the insurer or an ALJ. If the claimant does so, the respondents are not liable for the unauthorized treatment. *Yeck v. Industrial Claim Appeals Office,* 996 P.2d 228 (Colo. App. 1999).

21. If upon notice of the injury the employer fails forthwith to designate an ATP, the right of selection passes to the claimant. *Rogers v. Industrial Claim Appeals Office,* 746 P.2d 565 (Colo. App. 1987). The employer's obligation to appoint an ATP arises when it has some knowledge of the accompanying facts connecting an injury to the employment such that a reasonably conscientious manager would recognize the case might result in a claim for compensation. *Bunch v. Industrial Claim Appeals Office,* 148 P.3d 381 (Colo. App. 2006).

22. Authorized providers also include providers to whom an ATP refers the claimant in the normal progression of authorized treatment. *Town of Ignacio v. Industrial Claim Appeals Office,* 70 P.3d 513 (Colo. App. 2002); *City of Durango v. Dunagan,* 939 P.2d 496 (Colo. App. 1997). Whether an ATP has made a referral in the normal progression of authorized treatment is a question of fact for the ALJ. *Suetrack USA v. Industrial Claim Appeals Office,* 902 P.2d 854 (Colo. App. 1995).

23. A claimant may also obtain "authorized treatment" without giving notice and obtaining a referral from the employer if the treatment is necessitated by a bona fide emergency. Once the emergency is over the employer retains the right to designate the first "non-emergency" physician. *Sims v. Industrial Claim Appeals Office,* 797 P.2d 777 (Colo. App. 1990).

24. Respondents are liable to provide medical treatment that is reasonable and necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. 2005. The question of whether the claimant proved treatment is rea-

sonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002).

25. Section 8-43-404(5)(a)(I)(A) C.R.S., applicable to this 2008 injury and claim for benefits, provides that:

> "In all cases of injury, the employer or insurer shall provide a list of at least two physicians or two corporate medical providers or at least one physician and one corporate medical provider, where available, in the first instance, from which list an injured employee may select the physician who attends said injured employee."

The statute further provides that if "the services of a physician are not tendered at the time of injury, the employee shall have the right to select a physician or chiropractor."

26. This statute affords the employer the right to designate at least two physicians and/or corporate providers that are deemed authorized to provide medical treatment. Consistent with the version of § 8-43-404(5)(a) that was amended in 1997, the current version provides that the employer's right to designate the authorized providers may be lost and the right of selection passed to the claimant if medical services are not tendered "at the time of injury." *See Rogers v. Industrial Claim Appeals Office,* 746 P.2d 565 (Colo. App. 1987).

27. The ALJ concludes that the treatment provided at Anmed Health following the accident and during the claimant's hospital stay in May 2009 was the result of a bona fide emergency and was authorized.

28. The ALJ concludes that Employer knew of Claimant's injury the day it happened but did not refer Claimant to an authorized physician or provider. In these circumstances the ALJ concludes that the right of selection passed to Claimant and he selected Dr. Frank Morgan as the ATP for his physical injuries and Charles Johnson, D.D.S. for the dental injuries. Dr. Morgan referred Claimant to Dr. Matthew Uyemura who referred Claimant to the Aschziger Vision Center. Dr. Morgan also referred Claimant to Dr. Hans Coester who referred Claimant to Dr. Reichhardt. These medical providers are all authorized.

29. On Approximately June 18, 2009, Claimant received notice from Employer's representative that Dr. Jeff Wunder had been designated as his ATP. Although Employer has not provided Claimant with a list of providers pursuant to W.C.R.P. 8-2 (D), Claimant had already chosen Dr. Morgan as his ATP and is not free to choose another ATP. Therefore, Claimant's request to have Dr. L. Barton Goldman assigned as his ATP is denied. Dr. Wunder is, in effect, another ATP along with Dr. Morgan and his referrals.

30. Claimant argues that once Employer refused to authorize any further medical care provided by Dr. Wunder (pending the outcome of litigation), the right to se-

lect a treatment provider reverted to Claimant and Claimant again seeks treatment with Dr. L. Barton Goldman as the authorized treatment provider. This request is denied. The ALJ concludes that cases holding that once the ATP is "selected" the claimant may not change physicians or employ additional providers without obtaining permission from the insurer or exercising a right granted by statute remain good law. This is true because the current version of § 8-43-404(5)(a)(I)(A) still gives the employer the initial right to designate the authorized provider, and the respondents still remain interested in the selection of the ATP since they are liable to pay for the medical treatment. *See Yeck v. Industrial Claim Appeals Office,* 996 P.2d 228 (Colo. App. 1999).

TEMPORARY TOTAL DISABILITY BENEFITS

31. Claimant seeks an award of temporary total disability (TTD) benefits commencing May 10, 2009, and continuing until terminated by law or order. The ALJ concludes Claimant is entitled to an award of TTD benefits.

32. To prove entitlement to TTD benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995); *City of Colorado Springs v. Industrial Claim Appeals Office,* 954 P.2d 637 (Colo. App. 1997). Section 8-42-103(1)(a), C.R.S., requires the claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v. Charles J. Murphy & Co.*, 964 P.2d 595 (Colo. App. 1998). TTD benefits ordinarily continue until one of the occurrences listed in § 8-42-105(3), C.R.S.; *City of Colorado Springs v. Industrial Claim Appeals Office, supra*.

33. The existence of disability presents a question of fact for the ALJ. There is no requirement that the claimant produce evidence of medical restrictions imposed by an ATP, or by any other physician. Rather, lay evidence alone may be sufficient to establish disability. *Lymburn v. Symbios Logic,* 952 P.2d 831 (Colo. App. 1997).

34. The ALJ concludes that claimant proved it is more probably true than not that he is entitled to an award of TTD benefits commencing May 10, 2009, and continuing. Claimant credibly testified that he has been unable to return to work since the motor vehicle accident of May 10, 2009. Claimant's testimony is corroborated by the medical evidence showing that Claimant has not been released to return to work. No credible or persuasive evidence establishes that Claimant's right to receive TTD benefits has been terminated in accordance with law or order.

ORDER

It is therefore ordered that:

1. Employer shall pay Claimant interest at the rate of 8% per annum on compensation benefits not paid when due.

2. Issues not resolved by this order are reserved for future determination.

3. Employer shall pay Claimant TTD benefits commencing May 10, 2009, and continuing until terminated by law or order. The TTD benefits shall be paid at the rate of $336.30, and shall be calculated based on the AWW of $504.45.

4. Employer shall pay Claimant's reasonable and necessary medical expenses resulting from the industrial injury including the treatment and services provided by Anmed Health, Dr. Morgan, Dr. Uyemura, Dr. Coester, Dr. Green, Charles Johnson, D.D.S., Aschziger Vision Center, Dr. Reichhardt, Dr. Wunder and all their referrals. Payment shall be made in accordance with the fee schedule.

5. Pursuant to the stipulation of the parties, Employer shall offset $1000.00 against the TTD due and owing.

to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

DATED: January 8, 2010

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-785-795

ISSUES

1. A determination of Claimant's Average Weekly Wage (AWW).

2. Whether Claimant has established by a preponderance of the evidence that she is entitled to receive Temporary Partial Disability (TPD) benefits for the period April 13, 2009 until terminated by statute.

3. Whether Claimant has demonstrated by a preponderance of the evidence that she is entitled to receive authorized medical treatment in the form of additional physical therapy that is reasonable and necessary to cure or relieve the effects of her industrial injury.

FINDINGS OF FACT

1. Claimant is a 29-year-old female who was born on September 28, 1980. She works for Employer as a sales representative who serviced client accounts. Claimant's job duties involved visiting prospective customers and selling wine, beer, and spirits. She also occasionally stocked her products on customers' shelves. Claimant's position required her to lift up to 50 pounds of products.

2. On June 2, 2008 Claimant suffered an admitted industrial injury to her left foot and left hip during the course and scope of her employment with Employer. Claimant had been involved in a motor vehicle accident.

3. On August 27, 2009 Respondents filed a General Admission of Liability (GAL) in this matter. The GAL acknowledged that Claimant had earned an AWW of $807.86. Claimant's AWW was based on her earnings for the six months from August 2008 until January 2009.

4. Claimant testified at the hearing in this matter. She explained that her earnings were based primarily on commissions. Claimant's commissions were predicated on a number of factors including the amount of products that she sold, the number of new customers that she obtained and various incentives. She remarked that the sales volume of her products varies throughout the year. Claimant specifically noted that in certain months wine sales increase and in other months beer sales increase. She commented that her commissions have increased by approximately $5,000 each year for the three years she has worked for Employer.

5. Claimant's 2008 W-2 form reflects annual earnings of $55,296.41. Dividing $55,296.41 by 52 reveals weekly earnings of $1,063.39 for 2008.

6. Claimant received conservative medical treatment for her left foot and left hip injuries. However, because her condition did not improve, she underwent left hip surgery on February 24, 2009. Claimant explained that she was not assigned any work restrictions until after she underwent surgery. The restrictions included no lifting, pushing or pulling in excess of 15 pounds.

7. Claimant received Temporary Total Disability (TTD) benefits and TPD benefits during the period February 24, 2009 through April 12, 2009. Although Claimant continued to have work restrictions, Employer discontinued her disability benefits on April 13, 2009 because she had returned to her full earnings.

8. Claimant explained that, because of her work restrictions, she has suffered decreased earnings since April 13, 2009. She remarked that she was unable to service her customer accounts in the same fashion that she had serviced them prior to her February 24, 2009 surgery. Claimant specifically noted that her 15-pound lifting restriction prevented her from carrying an adequate amount of products into a customer's establishment in order to service the account. She commented that her sales suffered because her restrictions prohibited her from presenting her products in an effective manner. Furthermore, Claimant noted that her restrictions prevented her from restock-

ing and maintaining customer displays. She stated that her inability to help with displays made it more difficult for her to gain and maintain customer accounts.

9. Claimant's supervisor Phil Sauer testified at the hearing in this matter. Mr. Sauer explained that Claimant was required to visit her top 20 clients once each week and visit all of her approximately 52 clients every two weeks. He stated that Employer did not limit the amount of time Claimant could spend with each client and she could choose the amount of products she wanted to take into each customer's establishment. Mr. Sauer commented that Employer provided assistance to Claimant in loading her vehicle with products, but acknowledged that Employer did not assist Claimant with unloading her products at customer establishments. He remarked that Employer's business has been adversely affected by economic conditions and that product sales have thus declined.

10. Authorized Treating Physician (ATP) Craig S. Anderson, M.D. has requested additional physical therapy treatment for Claimant. In an August 20, 2009 letter he explained that Claimant has received the maximum amount of physical therapy recommended in the Medical Treatment Guidelines (Guidelines). Dr. Anderson commented that Claimant has demonstrated "substantial improvement in her ability to perform activities of daily living, including strength and range of motion." However, Claimant has experienced "extreme pain in the hip flexor tendons and muscles at the anterior hip." Dr. Anderson explained that additional physical therapy was warranted in order to improve her ability to lift and otherwise complete her job duties.

11. Claimant explained that physical therapy reduced the pain in her hip area. However, her pain level has increased since the termination of physical therapy.

12. On August 24, 2009 Jon Erickson, M.D. recommended the denial of Claimant's request for additional physical therapy. He expressed concern that Claimant still required physical therapy even though she underwent hip arthroscopic surgery six months earlier.

13. On September 16, 2009 Douglas Scott, M.D. also recommended the denial of additional physical therapy for Claimant. He noted that Claimant had already undergone six months of physical therapy. However, the physical therapy notes did not reveal any improvement in range of motion or strengthening of Claimant's hip.

14. Claimant underwent an independent medical examination with Andrew W. Parker, M.D. In a November 16, 2009 report Dr. Parker considered Claimant's request for additional physical therapy. He noted that Claimant suffers from residual stiffness and discomfort in her hip. Dr. Parker stated that "capsular stiffness" was probably causing the delay in Claimant's recovery. He explained "after 60+ physical therapy visits I do not feel that additional physical therapy will provide her with relief of this ongoing and relatively static problem." Dr. Parker determined that Claimant had not reached Maximum Medical Improvement (MMI) and that additional interventions could improve Claimant's hip range of motion. He thus recommended a referral to a hip specialist for any additional procedures to remedy her underlying, recurrent hip stiffness.

15. An AWW of $1,063.39 constitutes a fair approximation of Claimant's earnings as reflected in her 2008 W-2 form. Claimant's 2008 W-2 form reveals annual earnings of $55,296.41. Dividing $55,296.41 by 52 reflects weekly earnings of $1,063.39 for 2008. Claimant credibly explained that her commissions were predicated on a number of factors including the amount of products that she sold, the number of new customers that she obtained and various incentives. She remarked that the sales volume of her products varies throughout the year. Claimant specifically noted that in certain months wine sales increase and in other months beer sales increase. Therefore, Respondents calculation of an AWW in the amount of $807.86 based on Claimant's earnings for the six months from August 2008 until January 2009 is not an accurate reflection of her earnings.

16. Claimant has demonstrated that it is more probably true than not that she is entitled to receive TPD benefits for the period April 13, 2009 until terminated by statute. Claimant credibly explained that, because of her work restrictions, she has suffered decreased earnings since April 13, 2009. She remarked that she was unable to service her customer accounts in the same fashion that she had serviced them prior to her February 24, 2009 surgery. Claimant commented that her sales suffered because her 15-pound lifting restriction prohibited her from presenting her products to customers in an effective manner. Furthermore, because her restrictions prevented her from restocking and maintaining customer displays she has had difficulties in gaining and maintaining customer accounts. Although Mr. Sauer testified that economic conditions have adversely affected Employer's business, his general comments are outweighed by the negative impact that Claimant's lifting restrictions have had on her earnings.

17. Claimant has failed to establish that it is more probably true than not that she is entitled to authorized medical treatment that is reasonable and necessary to cure or relieve the effects of her industrial injury. She has specifically failed to demonstrate that she is entitled to additional physical therapy sessions in excess of the Guidelines. Dr. Anderson explained that additional physical therapy was warranted in order to improve Claimant's ability to lift and otherwise complete her job duties. However, doctors Erickson and Scott questioned why Claimant still required physical therapy when she had undergone physical therapy for six months without improvement. More importantly, Dr. Parker noted that Claimant's residual hip stiffness and discomfort was probably causing the delay in her recovery. He persuasively explained that, because Claimant has already had in excess of 60 physical therapy visits, additional physical therapy would unlikely provide relief from her "ongoing and relatively static problem." Dr. Parker determined that Claimant had not reached MMI and that additional interventions could improve her hip range of motion. He thus recommended a referral to a hip specialist for any additional procedures to remedy her underlying, recurrent hip stiffness. Because Claimant has already undergone in excess of 60 physical therapy sessions without improvement and still suffers from hip stiffness, medical providers are attempting to address Claimant's underlying problems. Therefore, Claimant's request for additional physical therapy in excess of the Guidelines is denied.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

AWW

4. Section 8-42-102(2), C.R.S. requires the Judge to determine a claimant's AWW based on her earnings at the time of injury. The Judge must calculate the money rate at which services are paid to the claimant under the contract of hire in force at the time of injury. *Pizza Hut v. ICAO,* 18 P.3d 867, 869 (Colo. App. 2001). However, §8-42-102(3), C.R.S. authorizes a Judge to exercise discretionary authority to calculate an AWW in another manner if the prescribed methods will not fairly calculate the AWW based on the particular circumstances. *Campbell v. IBM Corp.,* 867 P.2d 77, 82 (Colo. App. 1993). The overall objective in calculating an AWW is to arrive at a fair approximation of a claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997). Therefore, §8-42-102(3), C.R.S. grants an ALJ substantial discretion to modify the AWW if the statutorily prescribed method will not fairly compute a claimant's wages based on the particular circumstances of the case. *In Re Broomfield,* W.C. No. 4-651-471 (ICAP, Mar. 5, 2007).

5. As found, an AWW of $1,063.39 constitutes a fair approximation of Claimant's earnings as reflected in her 2008 W-2 form. Claimant's 2008 W-2 form reflects annual earnings of $55,296.41. Dividing $55,296.41 by 52 reflects weekly earnings of $1,063.39 for 2008. Claimant credibly explained that her commissions were predicated

on a number of factors including the amount of products that she sold, the number of new customers that she obtained and various incentives. She remarked that the sales volume of her products varies throughout the year. Claimant specifically noted that in certain months wine sales increase and in other months beer sales increase. Therefore, Respondents calculation of an AWW in the amount of $807.86 based on Claimant's earnings for the six months from August 2008 until January 2009 is not an accurate reflection of her earnings.

TPD Benefits

6. Section 8-42-103(1), C.R.S. requires a claimant seeking temporary disability benefits to establish a causal connection between the industrial injury and subsequent wage loss. *Champion Auto Body v. Industrial Claim Appeals Office*, 950 P.2d 671 (Colo. App. 1997). To prove entitlement to TPD benefits, a claimant must prove that the industrial injury caused a disability that contributed to some degree to a temporary wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). The term "disability," connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage earning capacity as demonstrated by claimant's inability to resume her prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that a claimant must present medical evidence from an attending physician to establish a physical disability. *See Lymbum v. Symbois Logic,* 952 P.2d 831 (Colo. App. 1997). Instead, a claimant's testimony is sufficient to demonstrate a temporary "disability." *Id.*

7. As found, Claimant has demonstrated by a preponderance of the evidence that she is entitled to receive TPD benefits for the period April 13, 2009 until terminated by statute. Claimant credibly explained that, because of her work restrictions, she has suffered decreased earnings since April 13, 2009. She remarked that she was unable to service her customer accounts in the same fashion that she had serviced them prior to her February 24, 2009 surgery. Claimant commented that her sales suffered because her 15-pound lifting restriction prohibited her from presenting her products to customers in an effective manner. Furthermore, because her restrictions prevented her from restocking and maintaining customer displays she has had difficulties in gaining and maintaining customer accounts. Although Mr. Sauer testified that economic conditions have adversely affected Employer's business, his general comments are outweighed by the negative impact that Claimant's lifting restrictions have had on her earnings.

Medical Benefits

8. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure or relieve the effects of an industrial injury. §8-42-101(1)(a), C.R.S.; *Colorado Comp. Ins. Auth. v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). The determination of whether a particular treatment modality is reasonable and necessary to treat an industrial injury is a factual determination for the ALJ. *In Re of Parker*, W.C. No.

4-517-537 (ICAP, May 31, 2006); *In re Frazier,* W.C. No. 3-920-202 (ICAP, Nov. 13, 2000).

9. As found, Claimant has failed to establish by a preponderance of the evidence that she is entitled to authorized medical treatment that is reasonable and necessary to cure or relieve the effects of her industrial injury. She has specifically failed to demonstrate that she is entitled to additional physical therapy sessions in excess of the Guidelines. Dr. Anderson explained that additional physical therapy was warranted in order to improve Claimant's ability to lift and otherwise complete her job duties. However, doctors Erickson and Scott questioned why Claimant still required physical therapy when she had undergone physical therapy for six months without improvement. More importantly, Dr. Parker noted that Claimant's residual hip stiffness and discomfort was probably causing the delay in her recovery. He persuasively explained that, because Claimant has already had in excess of 60 physical therapy visits, additional physical therapy would unlikely provide relief from her "ongoing and relatively static problem." Dr. Parker determined that Claimant had not reached MMI and that additional interventions could improve her hip range of motion. He thus recommended a referral to a hip specialist for any additional procedures to remedy her underlying, recurrent hip stiffness. Because Claimant has already undergone in excess of 60 physical therapy sessions without improvement and still suffers from hip stiffness, medical providers are attempting to address Claimant's underlying problems. Therefore, Claimant's request for additional physical therapy in excess of the Guidelines is denied.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant earned an AWW of $1,063.39.

2. Claimant shall receive TPD benefits for the period April 13, 2009 until terminated by statute.

3. Claimant's request for additional physical therapy visits is denied.

4. Any issues not resolved in this order are reserved for future determination.

DATED: January 8, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-756-677

ISSUES

1. Whether the Claimant is entitled to further treatment for the injury based on an alleged worsening of condition.
2. Whether the Claimant is entitled to maintenance medical treatment.

FINDINGS OF FACT

1. Claimant is a 55 year-old woman, who worked for Respondent-Employer as an associate area manager.
2. Claimant had neck and back problems that predate the industrial injury.
3. Specifically, Claimant was involved in a motor vehicle accident (MVA) in 1993. Claimant underwent a fusion at C5-6 in 1993. In November 1993, the Claimant was diagnosed with fibromyalgia due to the MVA. As a result of the MVA, the Claimant also had a neck fusion done in April *1994* at C6-7.
4. Claimant was in another MVA in July 1995. Claimant injured her head and neck in the accident. Claimant was diagnosed with a cervical strain secondary to the MVA.
5. In 1997, the Claimant was still seeking treatment for neck and right shoulder pain due to the 1993 MVA. Claimant told Dr. Nanes and Dr. Harper that she had a "long history of fibromyalgia" and a history of migraine headaches. Claimant also told Dr. Harper that her fibromyalgia was related to the 1993 MVA.
6. Claimant was diagnosed again with fibromyalgia in 1997. Claimant indicated that the fibromyalgia was the result of the 1993 MVA. Claimant was also diagnosed with migraine headaches. Subsequently, a rheumatologist examined the Claimant, who confirmed that the Claimant had fibromyalgia.
7. In January 1998, the Claimant inured her neck and head when some picture frames fell on the back of her head and her neck. Claimant had an x-ray of her thoracic spine taken.
8. In June 1999, the Claimant was involved in another MVA. Following the accident, the Claimant complained of neck pain. Pain diagrams also indicate that the Claimant complained of pain throughout the entire right side of her back.
9. On October 31, 2003, the Claimant slipped and fell on ice. As a result, the Claimant was seen for complaints of headaches and neck pain. On November 17, 2003, the Claimant complained of upper back and neck pain as a result of the slip and fall. An x-ray was taken of the Claimant's neck. In December 2003, the Claimant also complained of mid and low back pain following the slip and fall. Records also note that the Claimant had ongoing headaches ever since the October 31, 2003 fall.
10. Medical records from February 24, 2006 note that the Claimant has spondylolisthesis, grade I, at L5-S1.
11. Claimant injured her right shoulder in a work-related injury in August 2006. Claimant ultimately underwent a Division IME for this claim. Records from the Division IME note that the Claimant was also alleging neck pain as part of the August 2006 industrial injury.
12. Claimant had x-rays of her lumbar spine and thoracic spine taken in August 2006. The lumbar x-ray revealed anterolisthesis and degenerative changes at L5-S1. The thoracic x-ray revealed mild degenerative changes of the T8-9 disc space and a fusion at C6-7.

13. On January 27, 2007, Claimant was seen in the emergency room for complaints of pain in her shoulder and back that had been present since July 2006. On July 13, 2007, a cervical spine x-ray revealed a chronic anterior interbody fusion at C5-6, degenerative disc disease adjacent to the fusion, and straightening of the cervical lordosis.

14. Claimant was involved in another MVA on December 21, 2007. Claimant complained of increased back pain and neck pain following the accident. Dr. Sparr treated the Claimant for pain down the left side of her neck into her back and headaches. Claimant also complained of a pinching sensation at the bottom of her buttock. Claimant had MRIs of her lumbar spine and cervical spine taken in January 2008 as a result of the MVA. The lumbar MRI showed L5 spondylolysis and L5 degenerative disc disease with minor disc bulging. The cervical MRI showed a fusion at C6-7 and degenerative disc disease above and below the fusion with prominent anterior disc bulging. All of these events occurred approximately two months prior to the industrial injury that is the subject of this claim.

15. Claimant continued to treat for the MVA up until May 30, 2008. The Claimant received chiropractic treatment for the December 2007 MVA on March 14, 2008; only three days prior to the industrial injury.

16. Claimant sustained an admitted industrial injury with Respondent-Employer on March 17, 2008. Claimant was traveling with co-workers in a van between job sites when the van was hit from behind by another vehicle. Claimant sustained injuries to her neck and back.

17. Claimant treated for the industrial injury with Dr. Bradley at EmergiCare. Dr. Bradley placed the Claimant at MMI with no permanent impairment on June 6, 2008. Dr. Bradley opined that the Claimant did not require any maintenance treatment.

18. Claimant objected and underwent a Division IME with Dr. Bissell on March 23, 2009.

19. Dr. Bissell opined that the Claimant may have had a "minor soft tissue injury to her cervical, thoracic, lumbar and sacral spine regions as a result of her motor vehicle accident of March 17, 2008. She was treated appropriately for these sprain/strain injuries and they completely resolved. She now has recurrent axial spine pain that is most likely due to her history of chronic fibromyalgia and myofascial pain."

20. Dr. Bissell further opined that the Claimant was at MMI for the industrial injury with no permanent impairment. Dr. Bissell stated that the Claimant required no maintenance treatment for the industrial injury because her ongoing symptoms were caused by preexisting, non-work-related fibromyalgia. Dr. Bisselll did not note that the Claimant's condition had worsened since she was placed at MMI.

21. Claimant testified that she was not disputing whether she reached MMI on June 6, 2008 but instead was alleging that her condition has worsened post-MMI. Claimant has not produced sufficient medical reports to establish a change in condition since MMI. Claimant's evidence is her testimony that her condition has worsened.

CONCLUSIONS OF LAW

1. A workers' compensation case is decided on its merits. Cob. Rev. Stat. § 8-43201 (2003). It is the sole prerogative of the ALJ to assess the credibility of witnesses and the probative value of the evidence. *Monfort Inc. v. Rangel*, 867 P.2d 122 (Cob. App. 1993). An ALJ is not required to explicitly discuss defenses or theories he rejected and the findings can be implied by the ALJ's order. *Uptime Corp. v. Cob. Research Corp.*, 420 P.2d 232 (1966); *Mag-*

netic Engineering, Inc. v. Indus. Claim Appeals Office, 5 P.3d 385 (Cob. App. 2000). The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Id*.

2. Special burden of proof provided to Division IME (must overcome by clear and convincing evidence) does not apply to issues involving worsening of conditions and reopening. *Martinez v. K-Mart Corp.*, W.C. No. 4-164-054 (I.C.A.O. Sept. 2003).

3. A claim can be reopened for "an error, a mistake, or a change in condition." C.R.S. 8-43-303(1). A change in condition means "a change in the claimant's physical or mental condition resulting from the compensable injury." *Chavez v. Indus. Comm'n*, 714 P.2d 1328, 1330 (Cob. App. 1985) (quoting *Lucero v. Indus. Comm'n*, 710 P.2d 1191 (Cob. App. 1985)). Thus, a change in condition refers to either "a change in the condition of the original compensable injury or to a change in claimant's physical or mental condition which can be causally connected to the original injury." *Chavez*, 714 P.2d at 330.

4. Here, the Claimant is claiming a worsening of condition post-MMI. Claimant has not produced sufficient medical or other evidence to support a worsening of condition. Claimant's evidence is her testimony of subjective complaints of pain. There are not substantial objective findings to substantiate the Claimant's complaints.

5. The evidence shows that the Claimant's condition has not worsened post-MMI and that if she does require any treatment it is not related to the industrial injury. Specifically, Dr. Bissell, the Division IME, examined the Claimant approximately nine months post-MMI and less then three months prior to the Claimant filing her Application for Hearing and did not find the Claimant required any further treatment as a result of the industrial injury. In fact, Dr. Bissell opined that the Claimant's current symptoms and complaints were the result of preexisting non-work-related fibromyalgia.

6. Claimant has failed to establish by a preponderance of evidence that she suffered a material worsening of her work-related injury of March 17, 2008.

7. A claimant is entitled to medical benefits after MMI where there is substantial evidence in the record to support a determination that future medical treatment will be reasonable and necessary to relieve the effects of an industrial injury or prevent further deterioration of the claimant's condition. *Grover v. Indus. Comm'n*, 759 P.2d 705 (Cob. 1988); *Stollmeyerv. Indus. Claim Appeals Office*, 916 P.2d 609 (Cob. Ct. App. 1995).

8. Here, the Claimant has not provided sufficient evidence indicating that she requires *Grover*-type benefits. The medical opinions of Dr. Bradley and Dr. Bissell both state that the Claimant does not require maintenance treatment for the industrial injury. Specifically, Dr. Bissell opined that the Claimant "now has recurrent axial spine pain that is most likely due to her history of chronic fibromyalgia and myofascial pain." Dr. Bissell further opined that the Claimant's potential need for treatment is related to her pre-existing, non-work-related fibromyalgia and not the industrial injury.

9. Claimant has failed to establish by a preponderance of evidence that she requires post-MMI medical treatment related to her industrial injury of March 17, 2008.

ORDER

It is therefore ordered that:

Claimant's request for additional medical treatment due to a worsening of condition for her work-related injury of March 17, 2008 is denied and dismissed.

Claimant's request for additional medical treatment in the form of *Grover-type,* post-MMI treatment for her work-related injury of March 17, 2008 is denied and dismissed.

All matters not determined herein are reserved for future determination.
DATE: January 12, 2010

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-798-707

ISSUE

Whether Claimant has established by a preponderance of the evidence that he suffered a compensable lower back injury during the course and scope of his employment with Employer on April 30, 2009.

STIPULATIONS

1. The parties agreed that Claimant earned an Average Weekly Wage (AWW) of $470.54.

2. If Claimant suffered a compensable injury, Concentra Medical Centers is the authorized medical treatment provider.

FINDINGS OF FACT

1. On September 18, 2002 Claimant began working as an assembler for Employer. His duties specifically involved assembling cubicles.

2. Claimant testified at the hearing in this matter that he injured his lower back on April 30, 2009. He explained that he was moving an 80-pound cubicle tabletop with a less experienced coworker. The coworker released the tabletop sooner than Claimant expected and Claimant awkwardly absorbed the weight of the piece. Claimant remarked that he suffered immediate lower back pain. He noted that the incident occurred at approximately 8:00 a.m. but that he had a scheduled work break at 8:15 a.m. Claimant stated that his lower back pain decreased sufficiently so that he was able to resume his job duties after the break.

3. Claimant's coworker Brian Donnelly testified at the hearing in this matter. He stated that he worked with Claimant on April 30, 2009. Claimant did not mention that he had sustained any lower back injuries and Mr. Donnelly did not notice that Claimant had suffered any injuries. Mr. Donnelly remarked that Claimant was able to perform his regular job duties and did not appear to experience any discomfort. He summarized that Claimant did not mention any lower back concerns until mid-July 2009.

4. Claimant's supervisor Ron Harms testified at the hearing in this matter. He explained that Claimant did not report any industrial injury and was able to perform his regular job duties. Mr. Harms commented that Claimant did not appear to suffer back discomfort or any other symptoms until mid-July 2009.

5. On May 5, 2009 Claimant sought medical treatment from family provider Big Thompson Medical Group, Inc. (Big Thompson). He visited William J. Reents, M.D. for an evaluation. Claimant reported lower back pain, pain in his right leg into his knee and pain in his ankle. He noted that he had experienced his symptoms for a long time. Claimant did not report any industrial injuries. Although Claimant expressed concerns about his knee, Dr. Reents remarked that the knee symptoms constituted referred pain from the lower back. He concluded that Claimant suffered degenerative disc disease that caused sciatica.

6. On June 24, 2009 Claimant visited Big Thompson physician Anthony Cabrera, M.D. for an evaluation. He noted lower back pain that extended into his right buttock. Claimant also reported numbness in his lateral knee. He noted that he had suffered his symptoms for approximately two months. Claimant underwent x-rays of his knee and lower back. The knee x-rays were negative and the lower back x-rays revealed degenerative disc disease. Because Claimant's symptoms were not improving, Dr. Cabrera recommended a lower back MRI.

7. On June 30, 2009 Claimant underwent an MRI of his lower back. The MRI revealed disc desiccation and disc space narrowing at all levels. Claimant specifically had a mild, broad-based disc bulge at L5-S1 without superimposed focal or frank protrusion. Claimant also had a broad-based disc bulge at L4-L5 with a superimposed central disc protrusion. The radiologist summarized that Claimant suffered from "[m]ultiple degenerative spondylosis with associated disk pathology."

8. On July 10, 2009 Claimant and his daughter returned to Dr. Cabrera. After reviewing the MRI results Dr. Cabrera discussed the etiology of Claimant's symptoms and treatment options with Claimant and his daughter. He remarked that Claimant's daughter asked numerous questions about the cause of Claimant's condition and inquired whether running in an airport while carrying luggage could have triggered lower back symptoms. Dr. Cabrera concluded that Claimant probably suffered from a chronic condition that "could be exacerbated by acute things."

9. On July 13, 2009 Claimant reported to Employer that he had injured his lower back while performing his job duties on April 30, 2009. Employer directed Claimant to Concentra Medical Centers for treatment.

10. On July 13, 2009 Claimant visited Rosalinda Pineiro, M.D. for an evaluation. She diagnosed Claimant with lower back pain and radiculopathy. Dr. Pineiro sought to review Claimant's medical records from Big Thompson in order to ascertain whether his condition was related to his employment for Employer. In the absence of the records she opined that Claimant did not suffer a work-related injury.

11. Claimant returned to Dr. Pineiro for an examination on July 24, 2009. Dr. Pineiro stated that she had reviewed Claimant's treatment notes from doctors Reents and Cabrera. She remarked that the notes did not mention any type of work injury, but only an aggravation of back pain with heavy lifting. Dr. Pineiro commented that Claimant's daughter had asked another provider whether Claimant's back pain was related to lifting a heavy suitcase during a trip. However, the medical provider remarked that Claimant suffered from a chronic condition. Based on a review of the medical records and MRI results that revealed severe stenosis, Dr. Pineiro could not state with a reasonable degree of medical probability that Claimant's back symptoms were work-related.

12. On October 26, 2009 Claimant underwent an independent medical examination with Henry J. Roth, M.D. Dr. Roth issued a report and testified at the hearing in this matter. He primarily assessed the causation of Claimant's lower back condition. Dr. Roth concluded that Claimant's lower back symptoms and MRI results were not caused or aggravated by a work-related event on April 30, 2009. Dr. Roth explained that Claimant's MRI did not reveal an acute event but instead reflected ordinary degenerative changes in a 60-year old male. He remarked that none of Claimant's symptoms had been confirmed by spinal injections or EMG/nerve conduction studies. Dr. Roth's diagnoses included L4-L5 spinal stenosis and the entirely degenerative change of radiculopathy.

13. Dr. Roth also persuasively explained that, if Claimant suffered a work-related incident on April 30, 2009, it constituted a lumbar strain. He commented that a lumbar strain would have constituted the temporary exacerbation of a preexisting condition. Dr. Roth remarked that Claimant would have recovered from a lumbar strain within four to six weeks and would not continue to exhibit symptoms by October 26, 2009.

14. Claimant has failed to demonstrate that it is more probably true than not that he sustained a compensable lower back injury during the course and scope of his employment with Employer on April 30, 2009. He has failed to establish that a lifting incident at work on April 30, 2009 aggravated, accelerated, or combined with his pre-existing, degenerative lower back condition to produce a need for medical treatment. Initially, Claimant did not report any work incident to coworkers, his supervisor or his medical providers for approximately two and one-half months. Moreover, Claimant was able to perform his regular job duties and did not appear to experience any discomfort between April 30, 2009 and July 13, 2009.

15. The medical evidence also does not support Claimant's contention that he sustained a compensable lower back injury at work on April 30, 2009. Claimant's family physicians diagnosed him with the chronic condition of degenerative disc disease that

caused sciatica. Furthermore, based on a review of the medical records and MRI results that revealed severe stenosis, Dr. Pineiro could not state with a reasonable degree of medical probability that Claimant's back symptoms were work-related. Finally, Dr. Roth persuasively concluded that Claimant's lower back symptoms and MRI results were not caused or aggravated by a work-related event on April 30, 2009. He explained that Claimant's MRI did not reveal an acute event but instead reflected ordinary degenerative changes in a 60-year old male. Dr. Roth also determined that, if Claimant suffered a work-related incident on April 30, 2009, it constituted a lumbar strain. He commented that a lumbar strain would have involved the temporary exacerbation of a preexisting condition and would have resolved in four to six weeks.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. For a claim to be compensable under the Act, a claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office,* 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts,* W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has failed to demonstrate by a preponderance of the evidence that he sustained a compensable lower back injury during the course and scope of his employment with Employer on April 30, 2009. He has failed to establish that a lifting incident at work on April 30, 2009 aggravated, accelerated, or combined with his pre-existing, degenerative lower back condition to produce a need for medical treatment. Initially, Claimant did not report any work incident to coworkers, his supervisor or his medical providers for approximately two and one-half months. Moreover, Claimant was able to perform his regular job duties and did not appear to experience any discomfort between April 30, 2009 and July 13, 2009.

7. As found, the medical evidence also does not support Claimant's contention that he sustained a compensable lower back injury at work on April 30, 2009. Claimant's family physicians diagnosed him with the chronic condition of degenerative disc disease that caused sciatica. Furthermore, based on a review of the medical records and MRI results that revealed severe stenosis, Dr. Pineiro could not state with a reasonable degree of medical probability that Claimant's back symptoms were work-related. Finally, Dr. Roth persuasively concluded that Claimant's lower back symptoms and MRI results were not caused or aggravated by a work-related event on April 30, 2009. He explained that Claimant's MRI did not reveal an acute event but instead reflected ordinary degenerative changes in a 60-year old male. Dr. Roth also determined that, if Claimant suffered a work-related incident on April 30, 2009, it constituted a lumbar strain. He commented that a lumbar strain would have involved the temporary exacerbation of a preexisting condition and would have resolved in four to six weeks.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

Claimant's request for Worker's Compensation benefits is denied and dismissed.

DATED: January 12, 2010. Peter J. Cannici

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-781-144

ISSUES

The ICAO has determined that Claimant was an employee of Respondent at the time of the accident. The issues for determination in this order are compensability, medical benefits, average weekly wage, temporary disability benefits, disfigurement benefits, and additional compensation for failure to insure.

The issue of safety rule was raised at the hearing. However, neither party mentioned that issue in their position statements and that issue is regarded as abandoned.

FINDINGS OF FACT

1. Claimant was injured on July 25, 2008, when a horse fell onto her leg. Claimant's right femur was broken. Claimant was transported by ambulance to St. Thomas More Hospital. The accident occurred in the course and scope of Claimant's employment for Respondent.
2. Claimant underwent surgery on July 25, 2008, at St. Thomas More Hospital. The surgeon was Jacob F. Peterson, M.D. The surgery was a Closed Lockee Intramedullary Nailing. The surgery involved a three-inch incision.
3. Claimant was discharged from the hospital on July 31, 2008. Claimant was restricted to limited weight bearing on her right leg.
4. Claimant was unable to perform the duties of her employment with limited weight bearing on her right leg.
5. Following her release from the hospital, Claimant continued to be treated by Dr. Peterson. Dr. Peterson prescribed four weeks of physical therapy. Claimant began that therapy at St. Thomas More on August 28, 2008. Dr. Peterson also prescribed medications and home health care.
6. Claimant's medical expenses in the amount of $45,515.00 was paid by Claimant's health insurer, $103.09 was paid by Claimant, and $5,881.51 was still owed as of the date of the hearing.
7. Dr. Peterson examined Claimant on March 2, 2009. He noted that Claimant walked well with no limp and no atrophy. He stated that Claimant's fracture had healed with no evidence of complication. He released to her activity as tolerated. Claimant could have resumed the usual duties of her employment with this restriction.
8. Claimant was employed by Respondent from February 12, 2008, to July 25, 2008, a period of 163 days or 23.29 weeks. Claimant's wages averaged $54.11 per week.
9. As a result of the injury and surgery, Claimant has a three-inch long scar over her right knee. The scar is a dark purple color. Claimant also has four marks on her right leg.
10. Respondent did not carry workers' compensation insurance on the date of the accident.

CONCLUSIONS OF LAW

The ICAO has determined that Claimant was an employee at the time of the accident on July 25, 2008. Claimant has established by a preponderance of the evidence that she sustained an injury on July 25, 2008, in the course and scope of her employment. Section 8-41-301(1)(b), C.R.S. The claim is compensable.

Respondent is liable for the medical care Claimant has received that was reasonably needed to cure and relieve Claimant from the effects of the compensable injury. Section 8-42-101(1), C.R.S. Respondent shall reimburse Claimant's health insurer for the $45,515.87 that it paid for this injury. Respondent shall pay Claimant the $103.09 that she is out of pocket. Respondent shall pay the providers $5,881.51 that is still owed to the providers. No medical provider may seek to recover costs or fees from Claimant. Section 8-42-101(4), C.R.S.

Respondent is liable for temporary total disability benefits at the rate of two-thirds of Claimant's average weekly wage. Section 8-42-101(1), C.R.S. Respondent is not insured and therefore the temporary disability benefit rate is increased by fifty percent. Section 8-43-408(1), C.R.S. Claimant's average weekly wage is $54.11. Temporary total disability benefits with the increase for failure to insure are payable at the rate of $54.11 per week. Temporary total disability benefits commence on July 26, 2008.

Temporary total disability benefits end when one of the events enumerated in Section 8-42-105(3), C.R.S., occurs. Dr. Peterson, Claimant's attending physician, released Claimant to return to regular employment on March 2, 2009. Temporary total disability benefits end on that date. Section 8-42-105(3)(c), C.R.S. Temporary total disability benefits are payable from July 26, 2008, to March 2, 2009, a period of 31.4286 weeks. The total temporary total disability benefit due is $1,700.60.

Respondent is liable for interest at the rate of eight percent per annum on the temporary total disability benefits not paid when due. Section 8-43-410, C.R.S. As of December 31, 2009, interest totals $158.60. Interest accrues at the rate of $.41 per day after December 31, 2009.

As a result of the compensable injury, Claimant has sustained a serious permanent disfigurement to an area of her body normally exposed to public view. Respondent is liable for additional benefits for that disfigurement. Section 8-42-108(1), C.R.S. The maximum allowed for this disfigurement is $4,000.00. Having viewed the scars on Claimant's right leg, it is determined that $2,500.00 in additional benefits for disfigurement is appropriate in this claim.

An uninsured employer must post a bond or pay a deposit. Section 8-43-408(2), C.R.S. The amount of the bond or deposit is set at $56,000.00.

Permanent disability benefits and other issues not determined by this order are reserved.

ORDER

It is therefore ordered that:

1. Respondent shall reimburse Claimant's health insurer for the $45,515.87 that it paid for Claimant's medical care for this injury. Respondent shall pay Claimant the $103.09 that she is out of pocket for medical expenses. Respondent shall pay the providers $5,881.51 that is still owed to the providers for medical care for this injury.
2. Respondent shall pay Claimant $1,700.60 for temporary total disability benefits and additional benefits for failure to insure.
3. Respondent shall pay Claimant $158.60 for interest due as of December 31, 2009.
4. Respondent shall pay Claimant $2,500.00 in additional compensation for disfigurement.
5. In lieu of payment of the above compensation and benefits to Claimant, Respondent shall:

a. Deposit the sum of $56,000.00 with the Division of Workers' Compensation, as trustee, to secure the payment of all unpaid compensation and benefits awarded. The check shall be payable to: Division of Workers' Compensation/Trustee. The check shall be mailed to the Division of Workers' Compensation, P.O. Box 300009, Denver, Colorado 80203-0009, Attention: Sue Sobolik/Trustee; or

b. File a bond in the sum of $56,000.00 with the Division of Workers' Compensation within ten (10) days of the date of this order:
   (1) Signed by two or more responsible sureties who have received prior approval of the Division of Workers' Compensation; or
   (2) Issued by a surety company authorized to do business in Colorado.
   The bond shall guarantee payment of the compensation and benefits awarded.

It is further ordered that Respondent shall notify the Division of Workers' Compensation of payments made pursuant to this order.

It is further ordered that the filing of any appeal, including a petition to review, shall not relieve Respondent of the obligation to pay the designated sum to the trustee or to file the bond. Section 8-43-408(2), C.R.S.

Dated *January 12, 2009*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-726-429

ISSUES

Whether Claimant sustained a compensable occupational disease during the course and scope of his employment with Employer.

Was Claimant's claim barred by the applicable statute of limitations, Section 8-43-103(2), C.R.S.?

Who are Claimant's authorized treating providers and was his care and treatment received at National Jewish Hospital reasonable, necessary and related to his occupational disease?

FINDINGS OF FACT

1. Claimant has Alpha-1 Antitrypsin Deficiency, a genetic condition. Claimant worked for Employer from 1997 through May 2007 in the maintenance department. Claimant did not have significant respiratory problems prior to going to work for Employer in 1997 except for pneumonia in 1983.

2. Claimant was exposed to dust, smoke and fumes in the course of his employment from 1997 through May 2007. Claimant credibly testified to his various job duties and exposures at work including, but not limited to, dust from light fixture and ceiling fan installation, concrete dust from cutting/grinding grooves in concrete flooring, sawdust from woodworking in the wood shop, smoke from pipe soldering, and other miscellaneous exposures.

3. Ken Schmerber, an industrial hygienist, prepared an Assessment dated August 5, 2009, and also testified at hearing concerning his findings and opinions. Schmerber heard the testimony of Claimant. Schmerber stated Claimant's testimony was consistent with the information he obtained directly from Claimant in preparation of his Assessment. Schmerber testified Claimant was exposed to significant airborne contaminants during the course of his employment and what he considered to be "overexposures" experienced by Claimant at work. Schmerber testified Employer did no airborne exposure assessment nor was Claimant ever provided with respiratory protection that had been tested for effectiveness.

4. Claimant began experiencing symptoms associated with his Alpha-1 Antitrypsin Deficiency in 2001 after having worked for Employer for approximately four years. While medical records in 2001 indicate Claimant had a history of smoking, Claimant denied ever having smoked except for one cigarette as a young child and two marijuana cigarettes on later occasions. The testimony of Claimant regarding smoking was corroborated by the testimony of fellow employees Scott, Williams and Goodman who all testified they never witnessed Claimant smoking. Claimant's testimony is also corroborated by the testimony of Dr. Robert A. Sandhaus who testified he felt Claimant

was being truthful in his statement that he was a non-smoker and how mistakes are often found in medical records. Claimant's testimony that he was a nonsmoker is credible and persuasive.

5. Claimant's condition gradually deteriorated as his exposures at work continued. Nonetheless, Claimant was able to perform all of the duties of his employment until 2007. Beginning in 2007, Claimant was no longer able to perform all of the duties required of him at work due to emphysema. It was also in 2007 that Claimant first suffered a loss of income due to his condition.

6. Claimant was initially referred by Employer to Big Thompson Medical Group, Inc., because of reported problems with his cervical spine, right upper extremity and lower back. Claimant saw Dr. Prema Jacob on May 23, 2007. He reported a history of ten years of working for Employer with complaints of ongoing lung problems associated with inhalation of pollutants at work and a diagnosis of Alpha-1 Antitrypsin Deficiency. Dr. Jacob referred Claimant to National Jewish Hospital for treatment of his lung condition on May 23, 2007.

7. Claimant completed an Employee Occurrence Report on June 5, 2007. He described his exposures at work that caused burning in his lungs. Claimant also submitted a hand-written statement to Insurer at the time of his termination. He described multiple and repeated exposures at work during his ten years of employment.

8. An Employers' First Report of Injury was filed. A Notice of Contest was filed on June 18, 2007. Respondents denied liability for Claimant's emphysema. Claimant pursued evaluation and treatment at National Jewish Hospital where he saw Dr. Don Rollins and Dr. Robert Sandhaus.

9. In his November 14, 2007, report, Dr. Sandhaus stated:

> It is likely that [Claimant's] work environment has accelerated the development of his emphysema. Individuals with ZZ-type Alpha-1 may lead entirely normal lives with no evidence of lung disease. Lung disease is most commonly seen in Alpha-1 patients who have smoked cigarettes (which [Claimant] has not). Therefore, the most likely factors contributing to his severe lung problems are his frequent lung infections and his work environment with its exposure to dust and fumes.

10. Claimant attended an independent medical examination with Dr. Dennis Clifford. In his report dated May 22, 2008, Dr. Clifford stated that Claimant's occupational exposure played no role in the progression of his emphysema and that the progression of Claimant's disease would have been the same regardless of his exposures at work. Despite this opinion, Dr. Clifford also stated in his May 22, 2008, report:

> The patient is disabled and will need to avoid exposure to dust, fumes, etc. in the future because these are known to cause progression of the underlying Alpha-1 Antitrypsin once it is fairly established, as it is in [Claimant].

11. Dr. Robert Sandhaus testified at hearing. He is an expert in the field of pulmonary medicine and Alpha-1 Antitrypsin Deficiency. Dr. Sandhaus testified he presently treats approximately 450 families for Alpha-1 and helps manage approximately 3,000 other patients with this diagnosis. Dr. Sandhaus' expertise in his field was acknowledged by Respondents' expert, Dr. Dennis Clifford, who expressed a high degree of respect for Dr. Sandhaus and his expertise in the field of Alpha-1. Dr. Clifford admitted he has consulted with and referred his patients with Alpha-1 to Dr. Sandhaus. Dr. Sandhaus credibly testified that the deterioration in Claimant's condition from 1997 through 2007 was caused by Claimant's work-related exposures.

12. Dr. Sandhaus felt that 90 percent of Claimant's impairment was associated with his exposures at work and 10 percent due to prior respiratory infections. Dr. Sandhaus also stated that the minimal smoking history represented in the medical records could account for, at most, an additional 10 percent of Claimant's impairment if the records regarding Claimant's smoking history were accurate. Dr. Sandhaus stated he believed Claimant was a nonsmoker based on his interactions with Claimant.

13. Dr. Clifford also testified at hearing. Dr. Clifford was offered and accepted as an expert in the field of internal medicine and pulmonary disease. Dr. Clifford testified consistent with his May 22, 2008, report that Claimant's occupational exposure played no role in the progression of his emphysema. His testimony is inconsistent with the statement appearing on page 3 of his May 22, 2008, report wherein he stated exposure to dust, fumes, etc., are known to cause progression of underlying Alpha-1 Antitrypsin.

14. The opinions of Dr. Sandhaus are credible and persuasive. The opinions of Dr. Clifford are not persuasive as they are inconsistent and Dr. Clifford lacks the expertise in Alpha-1 Antitrypsin Deficiency held by Dr. Sandhaus.

15. There was some evidence of non-occupational exposures during the period of Claimant's employment with Employer as well as some evidence of occupational exposures prior to Claimant's employment with Employer. There is insufficient evidence that any such exposures contributed to the development and progression of Claimant's emphysema.

16. Claimant reasonably did not understand the seriousness and possible compensable nature of his condition until 2007, when he first became unable to perform all of his job duties due to his condition and he began to experience some loss of income associated with his condition.

CONCLUSIONS OF LAW

1. The purpose of the Workers' Compensation Act of Colorado (Act), Section 8-40-101, *et seq*., C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Except as specifically noted below, a claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of a claimant no in favor of the rights of respondents. Section 8-43-201, C.R.S.

2. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201. The ALJ's factual findings concern only evidence and inferences found to be dispositive of the issues involved; the ALJ has not addressed every piece of evidence or every inference that might lead to conflicting conclusions and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

3. Claimant credibly testified that he had no respiratory problems prior to going to work for Employer; that he suffered multiple and repeated exposures to dust, smoke and other airborne contaminants during the course of his employment; that said exposures caused his underlying condition to become symptomatic and that the continued exposures caused a progressive deterioration in his condition. The credible testimony of Dr. Robert Sandhaus supports Claimant's contention that his underlying Alpha-1 Antitrypsin Deficiency was asymptomatic prior to going to work for Loveland Good Samaritan and that Claimant's exposures at work from 1997 through 2007 caused the progression of his emphysema.

4. Claimant has established by a preponderance of the evidence that he sustained a compensable occupational disease as defined in Section 8-40-201 (14), C.R.S., with 90 percent of Claimant's impairment being occupational and 10 percent caused by non-occupational respiratory infections. There is insufficient evidence in the record to justify apportionment to non-occupational exposures or to occupational exposures prior to Claimant's employment with Employer. Pursuant to *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993), Respondents are liable for 90 percent of Claimant's benefits.

5. Although Claimant experienced symptoms from his Alpha-1 Antitrypsin Deficiency in 2001, Claimant was able to perform all the duties of his employment until 2007. Beginning in 2007, Claimant was unable to perform all of his job duties and also began to experience loss of income. Claimant reasonably did not understand the seri-

ousness and possible compensable nature of his injury until 2007, and the time for filing a claim did not begin to run until 2007. *City of Boulder v. Payne*, 426 P.2d 194, 197 (Colo. 1967); *City of Colorado Springs v. ICAO*, 89 P.3d 504 (Colo. App. 2004). Claimant notified Employer of the possible claim and Employer filed a First Report of Injury of June 11, 2007. Claimant's claim is therefore not barred by the statute of limitations found at Section 8-43-102 (2), C.R.S., as Claimant's claim was filed within two years of the onset of Claimant's disability in 2007.

6. Dr. Prema Jacob at Big Thompson Medical Group is an authorized provider for Employer. Dr. Jacob referred Claimant to National Jewish Hospital for treatment of his lung condition on May 23, 2007. Claimant was treated at National Jewish Hospital by Dr. Sandhaus and others. Pursuant to the referral of Dr. Jacob, National Jewish Hospital is an authorized provider. The treatment provided at National Jewish Hospital was reasonably needed to cure and relieve Claimant from the affects of the occupational disease. The Insurer is liable for 90 percent of the costs of Claimant's treatment at National Jewish Hospital.

ORDER

It is therefore ordered that:

1. Claimant sustained a compensable occupational disease during the course and scope of his employment with Employer.

2. Claimant's worker's compensation benefits should be apportioned 90 percent to his compensable occupational disease, 10 percent to his non-occupational respiratory condition.

3. Insurer is liable for 90 percent of the costs of Claimant's treatment at National Jewish Hospital.

4. Issues not determined herein are reserved for future determination.

DATED: *January 12, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-793-409

ISSUES

The issue determined herein is compensability. The parties stipulated to medical benefits and an average weekly wage of $947.49.

FINDINGS OF FACT

1. Claimant is employed as a plainclothes detective for the Employer. His normal working hours are from approximately 8:00 A.M. to 4:00 P.M., Monday through Friday. His working hours can vary because of investigative duties, surveillance, joint operations, and normal call-outs for incidents occurring before or after normal business hours. To facilitate his duties, he has been provided a semi-marked police vehicle.

2. Claimant lives in the Briargate subdivision in northern Colorado Springs, which is outside of the jurisdictional boundaries of the Employer. He regularly commutes to and from work in his assigned police vehicle.

3. The vehicle is readily identifiable as a police vehicle because the center console contains police equipment. The vehicle is also equipped with lights and antennas customarily found on semi-marked police vehicles. Claimant regularly used his police vehicle to travel to and from work. Although he was also permitted to use it for personal errands, he generally used his private vehicle for his personal business. The fact that Claimant commuted to and from work in a police vehicle increased the risk that he would be asked to provide assistance in an emergency situation.

4. The Employer has written policies concerning the actions to be taken by peace officer employees on-duty within the jurisdiction, off-duty within the jurisdiction, and on-duty outside the jurisdiction. The Employer has no written or oral policy regarding a peace officer's actions while off-duty and outside the Employer's jurisdiction.

5. On May 12, 2009 at approximately 8:15 A.M., claimant departed for work from his residence and became involved in an exigent situation approximately two blocks from his home. While driving up the street, he noticed a young child standing in the middle of the street facing away from him. When he approached in the patrol vehicle, she did not move away, but just turned and stared. The child was not responsive to communication and appeared to be in an altered mental state.

6. At that time, an adult approached Claimant's vehicle and asked claimant if he were a police officer. Claimant confirmed that he was a police officer. The adult requested assistance in controlling the child.

7. Immediately thereafter, the child began to run down the street in the direction that would ultimately take her to Union Boulevard during the morning rush hour. Claimant reasonably feared for the child's safety, so he gave chase in his vehicle. He circled around her in the patrol vehicle, at which time she stopped and ran in the oppo-

site direction. He then jumped out of the vehicle and chased her on foot. When Claimant grabbed the child, he planted his foot in an awkward manner and injured his left ankle.

8. Someone in the child's home had called 911, and Colorado Springs Police officers and paramedics arrived shortly thereafter. The child was subsequently transported to the Cedar Springs psychiatric hospital.

9. Claimant contacted the Employer from the scene and reported the injury. He was taken to Memorial Hospital and was diagnosed with a severely sprained ankle. Thereafter the Employer referred him to CCOM, where he saw Physician's Assistant Schultz and Dr. Dickson. A May 20, 2009 magnetic resonance image ("MRI") demonstrated significant damage, including tendon and ligament tearing. Claimant was referred to Dr. Groth, who performed a surgical repair on June 12, 2009.

10. Claimant has proven by a preponderance of the evidence that he suffered an injury on May 12, 2009, arising out of and in the course of his employment. Claimant had not yet logged in for the employer and was not paid for any services prior to logging in at work. He was not dispatched to the scene of the accident. Nevertheless, Claimant's injury has a sufficient nexus to the conditions of employment as a peace officer so that the injury arises out of and in the course of employment. Claimant did not suffer injuries in a motor vehicle accident while merely commuting to work. He specifically responded to a citizen request for assistance in exigent circumstances. His actions were similar to the actions that he performs as a certified peace officer for the employer. The employer has no specific written or oral policy governing this precise situation. Nevertheless, the Chief of Police agrees that the claimant acted appropriately, as would be expected for a peace officer employed by the employer, at least for actions within the State of Colorado. The Chief drew no distinction between a dispatch and a citizen call for help in exigent circumstances.

11. Additionally, the injury is compensable because claimant was commuting to work in a police vehicle. A "special circumstance" exists because the employer singled out claimant's travel for special treatment by providing transportation. The fact that claimant commuted to and from work in a police vehicle increased the risk that he would be asked to provide assistance in an emergency situation.

CONCLUSIONS OF LAW

1. Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). Claimant must prove entitlement to benefits by a preponderance of

the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). As found, claimant has proven by a preponderance of the evidence that he suffered an injury arising out of and in the course of his employment.

2. The general rule is that injuries sustained by employees going to and from work are not compensable. *Berry's Coffee Shop, Inc. v. Palomba*, 423 P.2d 212 (Colo. 1967). An exception to this general rule exists when "special circumstances" create a causal relationship between the employment and the travel, beyond the sole fact of the employee's arrival at work. *Madden v. Mountain West Fabricators*, 977 P.2d 861 (Colo. 1999). Many different cases have recognized exceptions from the general rule, including cases involving peace officers.

3. Respondents cite *Rogers v. Industrial Commission,* 574 P.2d 116 (Colo. App. 1978). In *Rogers*, a police officer with the Denver Police Department sought workers' compensation benefits for an accident that occurred while he was riding his personal motorcycle on his way to work. The officer argued that the requisite nexus to the employment was found in the police department's policy that he was required to be "always on duty." The court noted there was nothing about Roger's situation to exempt it from the usual "coming and going" rule. The court, however, stated that the controlling factor is whether, at the time of the accident, the officer was actually engaged in the performance of law enforcement activities. *Id.* at 118. In affirming the denial of compensability, the court specifically noted that Rogers was not performing any police duties in response to a direct order, responding to a call from a private person, or handling any emergency. He was merely traveling to work.

4. In contrast to the *Rogers* case, claimant's injury did not occur during a simple commute. Claimant did not have a motor vehicle accident while merely driving to work. He specifically responded to a citizen request for assistance in exigent circumstances. His actions were similar to the actions that he performs as a certified peace officer. This case is similar to *Conley v. Industrial Commission*, 601 P.2d 648 (Colo. App. 1979) in which death benefits were awarded to the widow of an off-duty police officer who was killed while directing traffic during a flood of the Big Thompson Canyon. The court primarily focused on the fact that the flood presented an emergency situation. *Id.* at 650. The court also noted that the decedent was performing duties that a police officer or sheriff's deputy would ordinarily perform in conjunction with such an emergency. Accordingly, the court held that the fact that decedent was off-duty prior to the onset of the emergency does not bar a claim for compensation. *Id.*

5. In addition, the fact that Claimant was commuting to work in a police vehicle is an important factor in whether his injury is compensable. "Special circumstances" have been found to exist if the employer singles out the employee's travel for special treatment as an inducement to employment by either providing transportation or paying the cost of the employee's travel. *Madden v. Mountain West Fabricators*, *supra.* Com-

pensation has typically been awarded when the employer provided the means of transportation, fuel, or the cost of commuting to and from a job site. For example, in *Industrial Commission v. Lavach*, 165 Colo. 433, 439 P.2d 359 (1968), the employee was killed in a motor vehicle accident while returning home from work. The employer provided the employee with a company truck and paid all of the expenses associated with the vehicle. The employee regularly used the company-provided vehicle for commuting to and from work. At the time of the accident, the employee was merely commuting home; he was not making any delivery or otherwise performing any service or function specifically related to his employment. Nevertheless, the court upheld an award of compensation, stating that "[w]here the employer agrees to provide its employee with the means of transportation or to pay the employee's cost of commuting to and from work, the scope of employment inferentially enlarges to include the employee's transportation." *Id.* at 438. *See also Staff Administrators, Inc. v. Reynolds*, 977 P.2d 866 (Colo.1999) (claimant injured in accident in his own vehicle awarded compensation because he missed opportunity to rendezvous with other workers who met at service station to carpool and obtain fuel customarily paid for by owner of construction company for work at construction site located a substantial distance from claimant's home and employer's place of business); *Monolith Portland Cement v. Burak*, 772 P.2d 688 (Colo.App.1989) (death benefits awarded where employer provided employee with automobile for use in traveling to and from work for business purposes and personal use); *Loffland Bros. v. Baca*, 651 P.2d 431 (Colo.App.1982) (employee who was injured in transportation provided to and from home by driller and who was paid on a mileage basis for transporting the other employees was entitled to compensation).

ORDER

It is therefore ordered that:

1. The insurer shall pay for all of claimant's reasonably necessary medical treatment by authorized providers, including Memorial Hospital, CCOM, Dr. Groth, and their referrals.

2. All matters not determined herein are reserved for future determination.

DATED: January 13, 2010

Martin D. Stuber

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-751-680

ISSUES

The issues determined herein are maximum medical improvement ("MMI") and medical benefits.

FINDINGS OF FACT

1. Claimant has a prior history of a partial right knee anterior cruciate ligament ("ACL") reconstruction performed in 1989. He suffered the injury when he stepped off a curb. He underwent arthroscopic surgery and then an open repair by Dr. Patterson. Prior to the surgery, Dr. Patterson informed claimant that the surgery might eventually cause the need for a total knee replacement ("TKR"). After about 30 days following the surgery, claimant suffered no residual problems with the right knee and needed no additional treatment.
2. Claimant returned to regular work and also acted as a sports official for local football, basketball, softball, baseball, and volleyball games. He continued to officiate multiple sporting events on almost a daily basis during all athletic seasons until his January 12, 2008 industrial injury.
3. Claimant suffered a compensable industrial injury to his right knee on January 12, 2008. At the time of his injury, Claimant was working as a material handler for his employer when he slipped on some ice, twisted his right knee, and fell to the floor onto his right kneecap.
4. Claimant was referred to the Employer's designated treatment provider, Centura Centers for Occupational Medicine ("CCOM"), where he was evaluated on January 14, 2008 by Dr. Mary Dickson. Dr. Dickson noted mild swelling, but no bruising. He was unable to flex his right knee. Dr. Dickson recommended an x-ray of the right knee as well as a magnetic resonance image ("MRI") of the right knee to rule out any internal derangement, including the possibility of a retear of the ACL or meniscus tear.
5. The January 14, 2008, x-ray demonstrated "mild degenerative changes" involving all three compartments of the right knee as well as "distention of the suprapatellar bursa on the lateral view consistent with a large joint effusion".
6. On January 16, 2008 Claimant underwent an MRI of the right knee without contrast which demonstrated:

    1. Tricompartmental chondromalacia affecting the medial patellofemoral compartment most significantly with cartilaginous defects in the femoral condyles.

    2. Abnormal signal in the posterior horn of the medial meniscus, not definitely contacting the articular surface. This may represent meniscal degeneration or prior meniscal repair. Intrasubstance tear cannot be entirely excluded but felt to be somewhat less likely.

    3. Mild-to-moderate joint effusion.

    4. The lateral meniscus, ACL, PCL, and collateral ligaments appear intact.

7. Claimant's care was transferred to Dr. Marty Kiernan, M.D. who conducted an initial evaluation on January 21, 2008. Dr. Kiernan provided conservative care primarily in the form of prescription medications, temporary physical restrictions to limit ambulation, and pool therapy.
8. Despite a pool wellness therapy program, Claimant failed to respond to conservative care. On February 6, 2008, Dr. Kiernan referred Claimant to Colorado Springs Orthopedic Group for further evaluation with the hope that aspirating the knee and in-

jecting it would lead to significant progress. On February 18, 2008, Dr. James Duffey examined claimant and noted minimal effusion. Dr. Duffey diagnosed advanced osteoarthritis of the right knee with significant worsening of symptoms following a work-related injury. Dr. Duffey recommended intra-articular steroid injections due to Claimant's inability to take anti-inflammatory medications. Dr. Duffey also recommended that Claimant consider visco supplementation if his pain relief was partial or temporary. Dr. Duffey concluded by indicating that Claimant was a candidate for TKR.

9. On March 17, 2008, Dr. Duffey noted that Claimant was a good candidate for visco supplementation but injection therapy could not commence because the procedure required pre-authorization.

10. Authorization for Synvisc injections was obtained and Claimant underwent his first injection on April 2, 2008. A second Synvisc injection was completed on April 10, 2008, and a third injection was provided on April 16, 2008.

11. On April 18, 2008, Dr. Kiernan noted that Claimant continued to suffer from pain in the right knee and was "walking with a fairly significant limp". Dr. Kiernan noted that Claimant was arranged to return to Dr. Duffey on May 8, 2008, to determine the effectiveness of the Synvisc therapy.

12. On May 8, 2008, Dr. Duffey reexamined Claimant, who reported no relief from the Synvisc injections. Dr. Duffey documented that non-operative measures had been exhausted, but claimant was a reasonable candidate for a total knee arthroplasty, for which Dr. Duffey would seek authorization.

13. On May 12, 2008, Claimant returned to Dr. Kiernan, who deferred to Dr. Duffey's recommendations.

14. On May 30, 2008, the insurer denied authorization for the TKR surgery based upon "compensability".

15. On September 23, 2008, Dr. James Lindberg performed an independent medical record review for respondents. Dr. Lindberg concluded that Claimant's degenerative arthritis preexisted the work injury. He recommended denial of a total knee arthroplasty under worker's compensation. According to Dr. Lindberg, Claimant should have a total knee arthroplasty "done under his own health insurance". Dr. Lindberg concluded that claimant did not suffer a major aggravation of the knee or acutely cause an exacerbation. Dr. Lindberg reviewed limited notes and did not obtain a history from the Claimant personally.

16. Dr. Kiernan then concluded that Claimant reached MMI on October 20, 2008, and set an appointment to complete range of motion testing and impairment rating.

17. On October 29, 2008, Dr. Kiernan provided his narrative report regarding MMI and impairment. In his October 29, 2008 report, Dr. Kiernan provided a final diagnostic impression of pain in the right knee with recurrent swelling. Dr. Kiernan provided an impairment rating of 39% of the lower extremity.

18. Respondents challenged the findings of Dr. Kiernan regarding impairment and requested a Division Independent Medical Examination ("DIME").

19. On March 4, 2009, Dr. Neil Pitzer performed an independent medical records review for respondents. Dr. Pitzer opined that Claimant's MRI failed to show any obvious acute injury such as meniscal tears, ligamentous disruption, or changes that could be reasonably attributed to an acute trauma, rather than a temporary aggravation of pre-existing arthritis. Dr. Pitzer concluded that Claimant aggravated his underlying pre-

existing arthritis, which "could have happened anywhere with any unusual movement and is not specifically a work injury." Dr. Pitzer agreed with Dr. Lindberg that a knee replacement procedure was not reasonably related to Claimant's work injury of January 12, 2008.

20. On April 21, 2009, Dr. Timothy Hall performed an IME for claimant. Dr. Hall noted that claimant suffered preexisting arthritis in the right knee, but he concluded that the work injury caused the onset of symptoms and the need for the TKR. Dr. Hall thought that Claimant "could have gone twenty years without needing a knee replacement if he didn't have trauma."

21. On June 11, 2009, Dr. Scott Hompland performed the DIME. Dr. Hompland determined that claimant was not at MMI because the work injury triggered the need for the right TKR, which would not normally have been required at that time. Dr. Hompland noted that the case was exceptionally complicated due to Claimant's pre-existing condition, but the medical records and claimant's history failed to establish that Claimant had pre-existing symptoms. Claimant was working without knee restrictions, was not taking any medication, was not under the care of a physician for his right knee, and was exceptionally active prior to his January 12, 2008 industrial injury. Claimant's industrial injury caused his need for a right TKR. Because the surgery had not been performed, Claimant was not yet at MMI.

22. Dr. Hompland made a clerical error on the IME Examiner's Summary Sheet when he mistakenly indicated that Claimant had reached MMI on October 29, 2008. On July 20, 2009, Dr. Hompland corrected the mistake on his IME Examiner's Summary Sheet by crossing out information that Claimant had reached MMI on October 29, 2008 and indicating clearly that Claimant was not at MMI. On August 6, 2009, the Division of Workers' Compensation Medical Services Delivery Section issued a Notice that the DIME report had been received determining Claimant not to be at MMI.

23. Claimant testified that after his ACL reconstructive surgery around 1989 he did not seek treatment for his knee and did not suffer debilitating pain or alteration in his functional activities until his January 12, 2008 work-related condition. This history was also provided to Dr. Hompland. Claimant's testimony is considered credible and persuasive.

24. At hearing, Dr. Pitzer testified consistent with his report. He noted that impact to the patella can cause a patellar cartilage defect, but the medical report immediately after the injury did not show bruising of the patella. He thought that claimant was at MMI for the work injury because he did not suffer any acute tears. Dr. Pitzer he admitted that Dr. Hompland's opinions simply differed from his and that Dr. Hompland utilized the appropriate criteria to determine causation for specific medical conditions.

25. Respondents have failed to prove by clear and convincing evidence that the determination by the DIME is incorrect. The opinions of Dr. Hompland, supprted by the opinions of Dr. Hall, are credible and persuasive. The contrary opinions of Dr. Pitzer and Dr. Lindberg do not demonstrate that it is highly probable and free from serious or substantial doubt that the DIME is incorrect. Consequently, claimant is not at MMI and needs the right TKR as a natural consequence of the admitted work injury.

CONCLUSIONS OF LAW

1. Section 8-42-107(8)(b)(III), C.R.S., provides that the determination of the DIME with regard to MMI shall only be overcome by clear and convincing evidence. The determination of the DIME concerning the cause of the claimant's impairment or need for medical treatment is binding unless overcome by clear and convincing evidence. *See Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Cudo v. Blue Mountain Energy Inc.*, W.C. No. 4-375-278 (Industrial Claim Appeals Office, October 29, 1999). A fact or proposition has been proved by "clear and convincing evidence" if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). In this case, the DIME, Dr. Hompland, determined that claimant was not at MMI. Consequently, respondents must prove by clear and convincing evidence that this determination is incorrect.

2. "Maximum medical improvement" is defined in Section 8-40-201(11.5), C.R.S. as:

> A point in time when any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition. The requirement for future medical maintenance which will not significantly improve the condition or the possibility of improvement or deterioration resulting from the passage of time shall not affect a finding of maximum medical improvement. The possibility of improvement or deterioration resulting from the passage of time alone shall not affect a finding of maximum medical improvement.

Reasonable and necessary treatment and diagnostic procedures are a prerequisite to MMI. MMI is largely a medical determination heavily dependent on the opinions of medical experts. *Villela v. Excel Corporation*, W.C. Nos. 4-400-281, 4-410-547, 4-410-548, & 4-410-551 (Industrial Claim Appeals Office, February 1, 2001). As found, respondents have failed to prove by clear and convincing evidence that Dr. Hompland erred in his determination that claimant was not yet at MMI for the work injury because the work injury caused the need for the TKR. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988).

ORDER

It is therefore ordered that:

1. The insurer shall pay for the cost of the right TKR, according to the Colorado medical fee schedule.

2. The issue of permanent partial disability benefits is not yet ripe for determination. All matters not determined herein are reserved for future determination.

DATED: January 13, 2010 Martin D. Stuber

Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-731-940

ISSUES

1. Whether or not the July 17, 2007 work-related injury to Claimant's back, caused Claimant to be unable to earn a wage in any capacity thereby rendering Claimant permanently and totally disabled?

2. In the event the July 17, 2007 work-related injury caused Claimant to be unable to earn a wage in any capacity, does apportionment apply regarding Claimant's pre-existing general health problems?

3. In the event the July 17, 2007 work-related injury caused Claimant to be unable to earn a wage in any capacity, does apportionment apply to Claimant's subsequent July 28, 2008 non work-related motor vehicle accident?

4. If Claimant is found, as a result of the subject work injury, to be unable to earn a wage in any capacity, are Respondents entitled to a retroactive and continued Social Security offsets.

5. If Respondents overpaid Claimant $5,364.80 in permanent partial disability benefits, are Respondents entitled to an overpayment of $5,364.80?

6. Is Claimant entitled to an additional disfigurement award?

I. STIPULATIONS

Claimant receives $611 in Social Security benefits that began on or around February 1996 and $96.40 in SI benefits for an offset amount of $707.40 in Social Security benefits.

FINDINGS OF FACT

1. Claimant injured himself on July 19, 2007, while an employee of the Respondent-Employer doing labor work in the horse stables. He was pushing a very heavy wheelbarrow up and over some two by fours. He had to push hard to get the wheelbarrow over a hole. He heard a pop in his back and developed low back pain. The pain radiated down his right buttock and leg which he described as severe and constant. He originally saw Dr. Kurish who referred him to Concentra Medical Centers. He then saw Dr. Baer who did an injection. A second injection gave him some relief. Ultimately, he saw Dr. Sung, a neurosurgeon, and had an L5-S1 wide decompression, L5-S1 anterior and posterior column arthodesis with screw implantation. Claimant believes he has "a lot of screws in his back."
2. He received care after the surgery, was placed at MMI and given a rating by his authorized treating physician, Dr. Hattem, and given permanent work restrictions that he not lift, push, pull objects weighing more than 5 pounds and that he be able to sit-stand as tolerable.
3. Claimant had a DIME performed by Dr. Finn who gave him a 15% whole person rating. He agreed with Dr. Hattem's MMI date of October 21, 2008.
4. Dr. Hattem and Dr. Finn collectively did not give Claimant any physical restrictions from his subsequent auto accident, nor did they apportion any impairment rating.
5. Claimant described his self-limitations as being able to sit or stand for about 15 minutes before his pain increases. He can walk short distances such as to his mailbox and back. His walking tolerance is a slow pace for 5 to 6 minutes with a cane. He agrees with the lifting, push-pull restrictions imposed by Dr. Hattem. He is fatigued all the time because the pain he is in prohibits him from getting a good night's sleep. His daughter drives him if he has to go anywhere. He states he can't do laundry, grocery shopping, cleaning or any other household chores. He watches TV and reads the Bible most of the day.
6. Claimant is 75 years old with an 8th grade education from Puerto Rico. He speaks, reads, and writes Spanish. He speaks English; reads some English including the Bible and want ads, and can write very little English.
7. Claimant has been in the United States since the 1950's and has basically done hard physical labor; farm work, construction, factory, and the like. He also ran a small Spanish film theater from 1970 to 1973. From 1978 to the 1980's, he booked some Spanish bands into small Spanish dance halls in Michigan.
8. Claimant has had two felony convictions. Both were for drugs. He as in federal prison from 1984 to 1987 and 1992 to 1995.
9. Claimant has done mainly physical labor all of his life. Both of Claimant's entrepreneurial ventures ended in failure. His experience in the theater was about 35 to 40 years ago. His wife helped him in the theater. His experience booking bands was about 30 to 35 years ago. His partner ran off with his money. Claimant's bookkeeping experience was writing down what came in and depositing it. His math skills are limited. He has had no training in bookkeeping, data entry, use of ledgers, balancing books, and so on. Claimant's negotiation skills with booking bands consisted of getting a date at the local dance hall and then calling the band, usually in Texas, to come perform. His promotional skills consisted of putting up posters. Claimant believes there are no jobs he

can do in light of his physical restrictions, job experience, job training, age, language skills, and other factors.

10. Bruce Magnuson was recognized as an expert in Vocational Rehabilitation. Mr. Magnuson opined that Claimant is permanently and totally disabled. His conclusion was that Claimant's age, past labor experiences, education, limited math skills, inability to write English, and his physical restrictions lead him to the determination that Claimant does not have any skills that would be currently compatible in any capacity with his residual functional capacity. He concluded Claimant is permanently and totally disabled.

11. Dr. Finn conducted the division independent medical evaluation (DIME) of the Claimant. Dr. Finn opined that Claimant's physical problems are related to his work injury and not anything else. He did not feel Claimant's pre-existing cardiac problems were the cause of Claimant's disability as he did heavy labor after a stent was implanted. He agreed with the physical restrictions. He did not agree that apportionment was appropriate under the circumstances.

12. Dr. Raschbacher testified for Respondents. His conclusion was that Claimant had a significant residual from the subsequent motor vehicle accident of July 28, 2008. Dr. Raschbacher gave Claimant lifting limits of 20 to 40 pounds. He did not find the ROM recently done or the care to be credible. He says the fact that Claimant flew to Puerto Rico after his surgery shows he can engage in something physically arduous.

13. Cynthia Bartmann testified for Respondents. In her vocational evaluation report, she states that the Claimant has basic experience taking inventory, bank deposits, light bookkeeping, negotiating leases, cashier and customer service. She opined that the Motel 6, AARP Foundation, Ambassador Adult Theater, American Plan USA, AMPC Parking, and Holland Residential are all places where the Claimant could work.

14. The Claimant sustained a disfigurement to his body as a result of the work related injury consisting of a vertical surgical scar running down the middle of Claimant's back being ten inches in length and three-quarters of an inch in width.

15. The ALJ finds Mr. Magnuson's opinions to be the more credible concerning Claimant's ability to earn a wage in any capacity and assigns greater weight to those opinions than to opinions to the contrary.

16. The ALJ finds Dr. Finn's opinions to be the more credible medical opinions concerning Claimant's medical condition and the relatedness of Claimant's condition to his industrial injury of July 17, 2007 and assigns greater weight to his opinions than to opinions to the contrary.

17. The parties' stipulated Claimant is receiving $707.40 per month in Social Security Benefits. The Claimant began receiving Social Security benefits on February 1996. As such, respondents are entitled to a retroactive Social Security disability offset.

18. On October 21, 2008, Dr. Al Hattem, M.D. assigned Claimant a 23% whole person impairment rating to Claimant's back. Thereafter, Claimant filed an Objection to the Final Admission of Liability and requested a Division IME. On March 16, 2009, Dr. Kenneth Finn, M.D. performed the Division IME. Dr. Finn agreed Claimant remained at medical maximum improvement but assigned Claimant a 15% whole person impairment rating.

19. On March 30, 2009, Respondents filed the Final Admission of Liability admitting to Dr. Finn's Division IME Report. Because Dr. Finn reduced Claimant's impairment rat-

ing, and because Respondents previously paid out to Claimant permanent partial disability benefits at 23% impairment rating, Respondents are entitled to recoup the overpayment from Claimant.

20. Respondent-Insurer has overpaid Claimant in the amount of $5,364.80 based upon the impairment rating provided by the ATP that was reduced by the DIME.

CONCLUSIONS OF LAW

1. Permanent Total Disability is defined by Section 8-40-201 (16.5)(a) as the Claimant's inability "to earn wages in the same or other employment." The burden of proof is on the Claimant to prove by a preponderance of the evidence that he is permanently and totally disabled. *Holly Nursing Care Center v. Industrial Claims Appeal Office*, 582 P.2d 701, (Cob. App. 1999). The ALJ may consider several human factors" in making the decision. The factors include, but are not limited to, the Claimant's physical condition, mental ability, age, employment history, education, and the availability of work the Claimant can perform. *Christie v. Coors Transportation Company*, 933 P.2d. 1330 (Cob. 1997) and *Weld County School District RE-12 v. Byner*, 955 P.2d. 550 (Cob. 1998).

2. An industrial injury does not need to be the sole cause of the Claimant's permanent and total disability. An employer takes the injured worker as it finds him and permanent total disability can be a combination of personal factors and a work-related injury. *Climax Molybdenum Co. v. Walter*, 812 P.2d. 1168 (Cob. 1991). Claimant has provided the most persuasive evidence that he is permanently and totally disabled and the July 19, 2007 industrial injury is a significant factor in his permanent and total disability.

3. Dr. Finn, the DIME doctor, felt the problems Claimant had were a result of the July 19, 2007 industrial accident. He did not feel Claimant's pre-existing cardiac problems were the cause of Claimant's disability as he did heavy labor after a stent was implanted. He agreed with the physical restrictions.

4. Dr. Hattem and Dr. Finn collectively did not give Claimant any physical restrictions from his subsequent auto accident, nor did they apportion any impairment rating.

5. In light of Claimant's age, language, math, and writing deficiencies, felony convictions, physical restrictions, and work experience Claimant has established by a preponderance of the evidence that he is permanently and totally disabled.

6. The court of appeals has affirmed the apportionment of permanent total disability benefits where the "disability" arises when the Claimant's baseline access to the labor market is reduced by injuries, illness, or aging processes. *Waddell v. Industrial Claim Appeals Office*, 964 P.2d 552, 554 (Colo. App. 1998); *Colorado Mental Health Institute v. Austil*, 940 P.2d 1125 (Colo.App. 1997).

7. In the case hereunder, the evidence is insufficient to establish that apportionment is required. Dr. Finn determined that apportionment was not an issue in his rating. Apportionment is an affirmative defense and the record does not establish by a preponderance of the evidence that apportionment is appropriate.

8. Based upon Claimant’s date of injury $4,000.00 is the maximum entitlement for disfigurement. The ALJ concludes that Claimant’s disfigurement establishes that an award of $2,000.00 is appropriate.

9. The parties’ stipulated Claimant is receiving $707.40 per month in Social Security Benefits. The Claimant began receiving Social Security benefits on February 1996. As

such, Respondents are entitled to a retroactive Social Security disability offset. The offset may be taken retroactively against previously paid workers' compensation disability benefits that should have been reduced in the first instance. Respondents are entitled to recover the "overpayment" of permanent disability benefits created by the retroactive Social Security award. *See* § 8-42-113.5, C.R.S. 2004; *Johnson v. Industrial Commission,* 761 P.2d 1140 (Colo. 1988).

10. C.R.S. §8-43-207(1)(q) provides "[h]earings shall be held to determine any controversy concerning any issue arising under articles 40 to 47 of this title. In connection with hearings, the director and administrative law judges are empowered to:

(q) Require repayment of overpayments.

11. On October 21, 2008, Dr. Al Hattem, M.D. assigned Claimant a 23% whole person impairment rating to Claimant's back. Thereafter, Claimant filed an Objection to the Final Admission of Liability and requested a Division IME. On March 16, 2009, Dr. Kenneth Finn, M.D. performed the Division IME. Dr. Finn agreed Claimant remained at medical maximum improvement but assigned Claimant a 15% whole person impairment rating.

12. On March 30, 2009, Respondents filed the Final Admission of Liability admitting to Dr. Finn's Division IME Report. Because Dr. Finn reduced Claimant's impairment rating, and because Respondents previously paid out to Claimant permanent partial disability benefits at 23% impairment rating, Respondents are entitled to recoup the overpayment from Claimant in the amount of $5,364.80.

ORDER

It is therefore ordered that:

1. Respondents shall pay Claimant permanent total disability benefits as determined by law, including provisions for offsets and overpayments.
2. Respondents' claim for apportionment is denied and dismissed.
3. Respondents shall pay Claimant $2,000.00 for disfigurement.
4. Respondents are entitled to a repayment of benefits based upon the offset for social security benefits previously paid.
5. Respondents are entitled recoup permanent partial disability benefits paid to Claimant that are in excess of the amount required to have been paid pursuant to the DIME determination of PPD resulting in an overpayment of $5,364.80.
6. The insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.
7. All matters not determined herein are reserved for future determination.

DATE: January 14, 2010

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-771-590

ISSUES

1. A determination of Claimant's Average Weekly Wage (AWW).

.2 Whether Claimant has proven by a preponderance of the evidence that he is entitled to receive Temporary Total Disability (TTD) benefits for the period July 29, 2008 until January 24, 2009.

FINDINGS OF FACT

1. Claimant worked as a carpenter for Miguel Jasso Perez. On July 28, 2008 Mr. Perez was employed as a subcontractor for Employer. Claimant was standing on scaffolding in excess of 10 feet above the ground. The scaffolding collapsed and Claimant fell to the ground. Claimant suffered admitted industrial injuries to his left leg, back and waist area. Mr. Perez was also injured during the incident.

3. Claimant and Mr. Perez received emergency medical treatment at the Sky Ridge Medical Center. Claimant suffered transverse process fractures from L2-L4.

4. On July 29, 2008 Claimant was discharged from the Sky Ridge Medical Center. The discharge instructions permitted Claimant to return to work without restrictions but advised him to follow-up with his primary care physician in one week.

5. Claimant did not seek medical treatment within one week but visited Aurora North Medical Center for treatment on August 25, 2008. He commented that he had not been working and reported lower back pain that had been slowly improving. The medical provider noted a "[l]ong and frank discussion with [Claimant] about the possible long term effects from this fall if he is to return to work full duty too soon." Claimant received a note that excused him from work until September 9, 2008. The note provided that Claimant would subsequently be released to work with restrictions.

6. Mr. Perez did not have Workers' Compensation insurance for his employees. Employer thus became liable for Claimant's medical treatment and disability benefits as the statutory Employer.

7. On September 29, 2008 Employer was apprised of Claimant's injuries and completed a First Report of Injury. Employer directed Claimant to obtain medical treatment from Authorized Treating Physician Clarence Kluck, M.D.

8. On November 25, 2008 Claimant visited Dr. Kluck for an evaluation. Dr. Kluck noted that Claimant had suffered transverse process fractures in his lower back at L2-L4. He determined that Claimant had not reached Maximum Medical Improvement

(MMI) but released Claimant to work full duty without restrictions effective November 25, 2008. Dr. Kluck instructed Claimant to return for an examination.

9. Claimant returned to Dr. Kluck for an evaluation on December 12, 2008. Dr. Kluck determined that Claimant could only return to modified work duty. He imposed temporary restrictions that prohibited Claimant from lifting, carrying, pushing or pulling in excess of 25 pounds.

10. Claimant continued to receive medical treatment from Dr. Kluck. On January 9, 2009 Dr. Kluck relaxed Claimant's temporary work restrictions and prohibited him from lifting, carrying, pushing or pulling in excess of 50 pounds. Dr. Kluck ultimately returned Claimant to full duty employment without restrictions on February 23, 2009.

11. Claimant testified at the hearing in this matter. He stated that he worked approximately 30 hours each week for Mr. Perez and earned $20.00 per hour. Claimant credibly commented that he was unable to perform his job duties after July 28, 2008 because of his lower back fractures. He explained that his carpentry duties required him to lift in excess of 25 pounds. Claimant remarked that he was unaware of the Workers' Compensation insurance situation regarding Mr. Perez and Employer until approximately two to three months after he was injured. He stated that he obtained full-time employment on January 25, 2009.

12. Claimant credibly testified that he worked approximately 30 hours each week and earned $20.00 per hour. An AWW of $600.00 thus constitutes a fair approximation of Claimant's wage loss and diminished earning capacity.

13. Claimant has proven that it is more probably true than not that he is entitled to receive TTD benefits from July 29, 2008 until January 24, 2009. On July 28, 2008 Claimant suffered admitted industrial injuries that included transverse process fractures from L2-L4. Claimant credibly testified that he was unable to perform his job duties after July 28, 2008 because of his lower back fractures. He visited Aurora North Medical Center for treatment on August 25, 2008. The medical provider noted a "[l]ong and frank discussion with [Claimant] about the possible long term effects from this fall if he is to return to work full duty too soon." Claimant received a note that excused him from work until September 9, 2008. Employer learned of Claimant's injuries on September 29, 2008 but Claimant did not visit ATP Dr. Kluck until November 25, 2008. Although Dr. Kluck initially released Claimant to full duty employment, he subsequently determined that Claimant could only return to modified work duty. He imposed temporary restrictions that prohibited Claimant from lifting, carrying, pushing or pulling in excess of 25 pounds. Dr. Kluck later relaxed the work restrictions and ultimately released Claimant to full duty employment without restrictions on February 23, 2009. Nevertheless, Claimant obtained full-time employment on January 25, 2009. A review of the medical records, in conjunction with Claimant's credible testimony, reflect that Claimant suffered a temporary disability that resulted in an actual wage loss because of his July 28, 2008 industrial injuries.

CONCLUSIONS OF LAW

1. The purpose of the “Workers’ Compensation Act of Colorado” (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge’s factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

Average Weekly Wage

4. Section 8-42-102(2), C.R.S. requires the Judge to determine a claimant's AWW based on her earnings at the time of injury. The Judge must calculate the money rate at which services are paid to the claimant under the contract of hire in force at the time of injury. *Pizza Hut v. ICAO,* 18 P.3d 867, 869 (Colo. App. 2001). However, §8-42-102(3), C.R.S. authorizes a Judge to exercise discretionary authority to calculate an AWW in another manner if the prescribed methods will not fairly calculate the AWW based on the particular circumstances. *Campbell v. IBM Corp.,* 867 P.2d 77, 82 (Colo. App. 1993). The overall objective in calculating an AWW is to arrive at a fair approximation of a claimant's wage loss and diminished earning capacity. *Ebersbach v. United Food & Commercial Workers Local No. 7*, W.C. No. 4-240-475 (ICAO May 7, 1997). Therefore, §8-42-102(3), C.R.S. grants an ALJ substantial discretion to modify the AWW if the statutorily prescribed method will not fairly compute a claimant’s wages based on the particular circumstances of the case. *In Re Broomfield,* W.C. No. 4-651-471 (ICAP, Mar. 5, 2007). As found, an AWW of $600.00 constitutes a fair approximation of Claimant’s wage loss and diminished earning capacity.

Temporary Total Disability Benefits

5. Section 8-42-103(1), C.R.S. requires a claimant seeking temporary disability benefits to establish a causal connection between the industrial injury and subse-

quent wage loss. *Champion Auto Body v. Industrial Claim Appeals Office*, 950 P.2d 671 (Colo. App. 1997). To demonstrate entitlement to TTD benefits a claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). The term "disability," connotes two elements: (1) medical incapacity evidenced by loss or restriction of bodily function; and (2) impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). There is no statutory requirement that a claimant must present medical evidence from an attending physician to establish a physical disability. *See Lymbum v. Symbois Logic,* 952 P.2d 831 (Colo. App. 1997). Instead, a claimant's testimony is sufficient to demonstrate a temporary "disability." *Id.*

6. As found, Claimant has proven by a preponderance of the evidence that he is entitled to receive TTD benefits from July 29, 2008 until January 24, 2009. On July 28, 2008 Claimant suffered admitted industrial injuries that included transverse process fractures from L2-L4. Claimant credibly testified that he was unable to perform his job duties after July 28, 2008 because of his lower back fractures. He visited Aurora North Medical Center for treatment on August 25, 2008. The medical provider noted a "[l]ong and frank discussion with [Claimant] about the possible long term effects from this fall if he is to return to work full duty too soon." Claimant received a note that excused him from work until September 9, 2008. Employer learned of Claimant's injuries on September 29, 2008 but Claimant did not visit ATP Dr. Kluck until November 25, 2008. Although Dr. Kluck initially released Claimant to full duty employment, he subsequently determined that Claimant could only return to modified work duty. He imposed temporary restrictions that prohibited Claimant from lifting, carrying, pushing or pulling in excess of 25 pounds. Dr. Kluck later relaxed the work restrictions and ultimately released Claimant to full duty employment without restrictions on February 23, 2009. Nevertheless, Claimant obtained full-time employment on January 25, 2009. A review of the medical records, in conjunction with Claimant's credible testimony, reflect that Claimant suffered a temporary disability that resulted in an actual wage loss because of his July 28, 2008 industrial injuries.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant earned an AWW of $600.00.

2. Claimant shall receive TTD benefits for the period July 29, 2008 until January 24, 2009.

3. Any issues not resolved in this Order are reserved for future determination.

DATED: January 14, 2009.

Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. 4-775-960

ISSUE

In determining Claimant's Average Weekly Wage (AWW), whether Respondents are entitled to an offset to reflect benefits available to Claimant through the American Recovery and Reinvestment Act of 2009 (ARRA).

FINDINGS OF FACT

1. On October 22, 2008 Claimant suffered admitted lower back injuries during the course and scope of his employment with Employer.

2. On April 30, 2009 Claimant was terminated from Employer's health insurance coverage.

3. On May 19, 2009 Claimant received notification that he could elect to continue his health insurance benefits through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

4. The ARRA provides for health insurance premium reductions under COBRA. Under the ARRA, covered individuals pay only 35% of their COBRA premiums and the remaining 65% is reimbursed to the coverage provider through a tax credit.

5. The premium reduction for COBRA continuation coverage is available to "assistance eligible individuals" under the ARRA. Claimant is an "assistance available individual." However, Claimant did not purchase COBRA continuation coverage and is no longer eligible to participate in the ARRA plan.

6. The cost of COBRA coverage is $1,730.18 per month or $399.27 each week.

7. While working for Employer Claimant paid $93.57 for COBRA benefits each week. Subtracting $93.57 from $399.27 yields the cost of continuing Claimant's health insurance benefits or $305.70 per week.

8. Claimant asserts that his AWW should be increased by $305.70 for health insurance.

9. Respondents assert that they are entitled to an offset representing 65% of the $305.70 or $198.71 based on COBRA premium assistance under the ARRA.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. The ARRA provides for premium reductions under COBRA. Pursuant to the ARRA, covered individuals pay only 35% of their COBRA premiums and the remaining 65% is reimbursed to the coverage provider through a tax credit. The premium reduction applies to periods of health coverage beginning on or after February 17, 2009 and lasts for up to nine months.

5. Section 3001 (a)(A) of the ARRA provides, in relevant part:

> [W]ith respect to any assistance eligible individual, such individual shall be treated for purposes of any COBRA continuation provision as having paid the amount of such premium **if such individual pays** (or a person other than such individual's employer pays on behalf of such individual) 35 percent of the amount of such premium**. . . .**

(emphasis added).

6. The premium reduction for COBRA continuation coverage is available to "assistance eligible individuals." An "assistance eligible individual" is the employee or a member of his family who is eligible for COBRA continuation coverage at any time between September 1, 2008 and December 31, 2009. The employee must have experienced an involuntary termination of coverage between September 1, 2008 and December 31, 2009. The employee must also earn an adjusted gross income of less than $125,000. American Recovery and Reinvestment Act of 2009, Pub.L. No. 111-5, Title III, § 3001(a)(3), 123 Stat. 155 (2009). As found, Claimant qualifies as an "assistance eligible individual" under the ARRA. However, Claimant did not purchase COBRA continuation coverage and is no longer eligible to participate in the ARRA plan.

7. Section 8-40-201(19)(b), C.R.S. provides that wages shall include the amount of an employer's costs of continuing the employee's costs of a group health insurance plan. The Supreme Court addressed the preceding statute in *ICAO v. Ray*, 145 P .2d 661 (Colo. 2006). In *Ray*, 145 P.3d at 668, the respondents argued that the claimant's entitlement to an increased AWW should not occur unless he actually purchased health insurance coverage. The Supreme Court rejected the respondents' argument and reasoned:

> The plain language of § 8-40-201(19)(b), C.R.S., says nothing that would require Claimant to purchase health insurance for the cost of insurance to be included in the average weekly wage. We agree with the Claimant that the text of our statute does not reference COBRA and does not require the actual purchase of health insurance.

8. Similar to the Supreme Court's reasoning in *Ray,* Claimant's AWW may be increased even though he did not purchase COBRA continuation coverage through the ARRA plan. The provisions of the ARRA are not triggered if an individual does not purchase health insurance under COBRA. Because Claimant did not pay the premium for continued health insurance coverage, the provisions of the ARRA are inapplicable. Accordingly, Claimant's AWW should be increased by his cost of continuing health insurance coverage under COBRA or $305.70.

ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's AWW shall be increased by $305.77 based on the cost of COBRA health insurance premiums.

2. Respondents shall pay Claimant interest at the rate of 8% per annum on all amounts of compensation not paid when due.

3. All issues not resolved by this Order are reserved for future determination.

DATED: January 19, 2010.

Peter J. Cannici
Administrative Law Judge
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-744-551

ISSUES

Whether Claimant's right shoulder injury occurring on December 24, 2008 is causally related to the admitted compensable injury.

Whether Claimant is entitled to payment of medical expenses for treatment of her right shoulder by Dr. James P. Lindberg, M.D. for the period from February 9 through May 5, 2009.

Whether Claimant is entitled to further medical treatment with the authorized treating physicians for her right shoulder as is reasonable and necessary.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant was employed as an aircraft mechanic for Employer. Claimant had been employed by Employer for 19 years as of the time of her injury on November 21, 2007.

2. Claimant sustained an admitted injury to her low back on November 21, 2007. On that date, Claimant was working to repair a seat in an airplane and became caught up in the framework of the seat while working underneath the seat. As Claimant twisted to remove herself, she felt a sharp pain in her low back.

3. Following her injury, Claimant was referred to Concentra Medical Center for treatment. Dr. Darrell Quick, M.D. of Concentra assumed Claimant's care beginning February 6, 2008 and became an authorized treating physician. Dr. Quick referred Claimant to Dr. Robert Kawasaki, M.D., a physical medicine and rehabilitation physician, and to Dr. Brian Reiss, M.D., an orthopedic surgeon.

4. Dr. Reiss performed surgery on Claimant on June 9, 2008 consisting of discectomy and fusion from L4 to L5-S1. Prior to that surgery, Dr. Kawasaki on January 28, 2008 had noted that Claimant had "somewhat of a right foot slap". (Dr. Jacobs' report, Exhibit 11, page four).

5. Following surgery, Dr. Kawasaki noted on October 16, 2008 that Claimant ambulated with evidence of a foot drop and a steppage type gait pattern with significant foot slap. On November 14, 2008 Dr. Kawasaki noted that Claimant continued with foot slap and occasional toe drag and that she "occasionally trips on her toes". (Dr. Jacobs' report, Exhibit 11, page six).

6. Prior to her injury on November 21, 2007 Claimant had developed a left foot drop condition as the result of several surgeries on her left lower leg. Claimant did not have a right foot drop condition prior to the injury of November 21, 2007. Prior to the injury of November 21, 2007 Claimant was not on any work restrictions for her left foot drop condition and did not have problems with walking or stumbling while walking.

7. Claimant's right foot drop condition prevents her from lifting the toes of her right foot and lifting her foot at the ankle. Claimant has weakness in the muscles of the right foot and ankle and loses her balance as a result. Claimant will catch her feet on the floor because of her abnormal gait. Claimant did not have any problems with her balance or with abnormal gait prior the injury of November 21, 2007.

8. On December 24, 2008 Claimant was at home and was walking from the family room area to the kitchen. While walking, Claimant fell because of her inability to pick up her feet due to the foot drop condition. Claimant fell on her outstretched right arm injuring her right shoulder.

9. Claimant was evaluated by Dr. Quick on December 31, 2008. Dr. Quick noted that Claimant had elements of bilateral ankle weakness and foot drop that had developed since her injury and surgery, with some difficulty with her gait. Dr. Quick further stated that Claimant had developed some progressive foot drop that had been observed by Dr. Kawasaki and himself. Dr. Quick opined, and it is found, that Claimant's symptoms of bilateral foot drop were substantially related to the surgery for Claimant's compensable low back injury.

10. Dr. Quick again evaluated Claimant on January 14, 2009 and noted a history that she had fallen and injured her right shoulder 2 –3 weeks ago.

11. Claimant was evaluated by her primary care physician, Dr. Jennifer Mix, D.O. on January 16, 2009. Dr. Mix obtained a history that Claimant had fallen on her outstretched right arm on Christmas Eve and now had shoulder pain. Dr. Mix further noted that Claimant had drop foot bilaterally and at times has difficulty walking. Dr. Mix suspected a Grade 2 injury of the right shoulder and referred Claimant for an MRI.

12. Claimant was re-evaluated by Dr. Reiss on February 6, 2009. Dr. Reiss noted that Claimant had dropped foot bilaterally with inability to raise her foot against gravity. Dr. Reiss obtained a history that because of her dropped foot Claimant had tripped over her foot and hit her shoulder and that Claimant questioned if this was related to her work injury due to the fact that her fall was caused by her foot being weak.

13. Dr. Quick referred Claimant to Dr. James Lindberg, M.D. for evaluation and treatment of her right shoulder condition. Dr. Lindberg initially evaluated Claimant on February 9, 2009. Dr. Lindberg gave Claimant two injections into the shoulder and last saw Claimant on May 5, 2009. At the time he last evaluated Claimant, Dr. Lindberg stated that if her symptoms worsened surgery consisting of subacromial decompression and excision of distal clavicle should be discussed.

14. Claimant underwent a Division-sponsored independent medical examination with Dr. Matthew Brodie, M.D. on July 16, 2009. Dr. Brodie noted on physical examination that Claimant had a substantial gait disorder with difficulty standing, walking and that Claimant stumbles when she walks. Dr. Brodie further noted that Claimant had substantial drop foot bilaterally and cannot actively extend her ankles or her great toes against gravity. Dr. Brodie noted Claimant's right shoulder problem but did not provide an opinion on its causal relationship to the admitted low back injury. Dr. Brodie noted that Claimant had constant right shoulder symptoms with worsening pain with movement of the shoulder.

15. At the request of Respondent, Claimant was evaluated by Dr. Alexander Jacobs, M.D. Dr. Jacobs performed a review of medical records provided to him regarding Claimant's work injury and her pre-existing left leg and foot drop conditions. With regard to the pre-existing left leg conditions, Dr. Jacobs stated, and it is found, that "After multiple surgeries, and with the consequent left foot drop, the patient continued to function and to work." Dr. Jacobs did not provide an opinion on whether Claimant's right shoulder injury was caused by a fall due to right foot drop, left foot drop or foot drop at all.

16. The ALJ finds Claimant's testimony, including her testimony regarding the circumstances and cause of her fall on December 24, 2008, to be credible and persuasive. Claimant has proven by a preponderance of the evidence that her fall on December 24, 2008 injuring her right shoulder is causally related to the effects of her admitted compensable low back injury on November 21, 2007 with Employer.

17. The treatment provided by Dr. James P. Lindberg, M.D. from February 9 through May 5, 2009 was reasonable and necessary to treat Claimant's right shoulder injury and Dr. Lindberg is found to be an authorized treating physician.

CONCLUSIONS OF LAW

18. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case

must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

19. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

20. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

21. Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any benefits are awarded. Section 8-41-301(1)(c), C.R.S.; *Faulkner v. Indus. Claim Appeals Office*, 12 P3d 844, 846 (Colo. App. 2000).

22. The evidence must establish the causal connection with reasonable probability, not medical certainty. *Ringsby Truck Lines, Inc. v. Industrial Commission, 491 P.2d 106 (Colo. App. 1971)*. Reasonable probability exists if the proposition is supported by substantial evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding. *F.R. Orr Construction v. Rinta, 717 P.2d 965 (Colo. App. 1985)*. An award of benefits may not be based upon or denied upon speculation or conjecture. *Deines Bros. v. Indus. Comm'n,* 125 Colo. 258, 242 P.2d 600 (1952); *Indus. Comm'n v. Havens,* 136 Colo. 111, 134 P.2d 698 (1957).

23. Colorado recognizes the "chain of causation" analysis holding that results flowing proximately and naturally from an industrial injury are considered to be compensable consequences of the injury. Thus, if the industrial injury leaves the body in a weakened condition and the weakened condition plays a causative role in producing additional disability the disability is a compensable consequence of the industrial injury. *Standard Metals Corp. v. Ball,* 172 Colo. 510, 474 P.2d 622 (1970); *Price Mine Service, Inc. v. Industrial Claim Appeals Office,* 64 P.3d936 (Colo. App. 2003); *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082 (Colo. App. 2002).

24. Both parties have characterized Claimant's December 24, 2008 fall as a "quasi-course of employment injury". The ALJ disagrees with this analysis for the reason that "quasi-course" injuries refer to injuries sustained when a claimant is in the process of seeking medical treatment for a compensable injury or involved in some other type of activity that is linked to responsibilities that flow from the compensable injury. That is not the case here. The ALJ concludes that Claimant's injury on December 24, 2008 is properly characterized as a "consequential injury", i.e. one that occurs or results as a consequence of the effects of the original compensable injury.

25. As found, Claimant has proven by a preponderance of the evidence that her fall on December 24, 2008 in which she injured her right shoulder occurred as a compensable consequence of her admitted low back injury. Respondent argues either that Claimant didn't actually fall and injure her shoulder or, in the alternative, that if Claimant's foot drop caused the fall, the foot drop is a pre-existing condition that is unrelated to the compensable injury. As found, Claimant's testimony is credible. While it is true that the histories taken by Dr. Quick in December 2008 and January 2009 do not contain mention of or specific details of the fall, at least as of the January 2009 visit Dr. Quick noted a history that is consistent with the Claimant having fallen as she alleged occurred on December 24, 2008, 2-3 weeks prior. A similar history is contained in the record from Dr. Mix at the time she evaluated Claimant on January 16, 2009. The ALJ concludes that sufficient, credible evidence exists that Claimant fell on December 24, 2008 and injured her right shoulder. Respondent has not presented persuasive evidence to show that Claimant's right shoulder injury occurred other than as alleged by Claimant.

26. The ALJ further finds and concludes that the fall on December 24, 2008 was caused by Claimant's foot drop condition that is causally related to the admitted low back injury. It is not disputed that prior to her November 2007 injury Claimant had suffered from a long-standing left foot drop condition. However, as credibly testified by Claimant and as noted by Dr. Jacobs in his report, this pre-existing condition did not affect Claimant's ability to walk or cause her to have problems with her balance, gait or with stumbling. After the November 2007 injury and the June 2008 lumbar surgery Claimant developed a significant right foot drop condition that now affected her ability to walk normally and, more significantly, began causing her difficulties with her balance related to her inability to lift or raise either foot against gravity. Prior to the injury of November 2007 Claimant was able to accommodate her left foot drop condition. After the November 2007 injury, the addition of the right foot drop condition now caused Claimant to experience significant difficulties with walking. As a result while walking on December 24, 2008 Claimant fell and injured her right shoulder. Respondent has not presented sufficient persuasive evidence that Claimant's fall on December 24, 2008 occurred as the result of an intervening cause unrelated to Claimant's compensable low back injury from November 2007.

27. As found, Dr. Lindberg is an authorized treating physician and his treatment of Claimant's right shoulder condition from February 9 through May 5, 2009 was reasonable and necessary. The ALJ concludes that Respondent should pay for the costs of Claimant's medical treatment with Dr. Lindberg as a compensable consequence of the November 21, 2007 injury. Although no specific treatment was requested for the future, the ALJ concludes that Respondent should remain liable for any further medical treatment for Claimant's right shoulder that is reasonable, necessary and casually related to the November 21, 2007 injury and that is provided by authorized treating physicians.

ORDER

It is therefore ordered that:

1. Claimant's injury to her right shoulder on December 24, 2008 occurred as a result of the effects of her admitted November 21, 2007 low back injury with Employer and is therefore compensable.

2. Respondent shall pay Claimant's medical expenses for treatment with Dr. James P. Lindberg, M.D. for the period from February 9 through May 5, 2009, according to the Official Medical Fee Schedule of the Division of Workers' Compensation.

3. Claimant is entitled to a general award of medical benefits from authorized treating physicians for her right shoulder from Respondent that are reasonable, necessary, and causally related to the November 21, 2007 injury.

All matters not determined herein are reserved for future determination.

DATED: January 19, 2010

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-778-532

ISSUES

The issues before the ALJ were compensability of Claimant's condition involving mental anguish and stress and the provision of medical benefits therefore.

FINDINGS OF FACT

1. Claimant was an employee of the Respondent-Employer for approximately four years prior to October 2008. Claimant had always received good performance evaluations up to this point and had also received bonuses for her performance.
2. Up until October 2008 Claimant felt that her employment was fine.
3. In October 2008 Kathy Stout became the President at the Respondent-Employer. While working under Ms. Stout Claimant felt a lot of pressure. Claimant missed a couple of weeks of work due to the stress.
4. Claimant's doctor informed her that she should file a workers' compensation claim. Claimant did so.
5. Claimant was referred to Concentra where she was advised that nothing was wrong with her.
6. On January 6, 2009 Claimant was terminated from employment.

7. Claimant provided a doctor's prescription excusing Claimant from work for three days in November 2008 due to stress.
8. There was no testimony by a licensed physician or psychologist to support Claimant's claim.

CONCLUSIONS OF LAW

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A Claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark,* 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.,* 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.
2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).
3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline,* 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).
4. For a claim to be compensable under the Act, a Claimant has the burden of proving that she suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson,* W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.,* 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner,* 12 P.3d at 846.
5. Section 8-41-301(2)(a) sets out the requirements for a Claimant to be able to recover for mental impairment. That section states in part, a "claim of mental impairment must be proven by evidence supported by the testimony of a licensed physician or psychologist."
6. The supreme court has held that expert testimony is necessary only to prove that an event was psychologically traumatic and that the other elements of § 8-41-301(2)(a) can be proved by lay testimony, expert testimony, or a combination thereof. *Davison v. Indus. Claim Appeals Office,* 84 P.3d 1023 (Colo.2004)(*Davison II*). Here, there was no expert testimony upon which the ALJ can find that Claimant underwent a psychologi-

cally traumatic event that would permit recovery. Thus, the ALJ is constrained to deny and dismiss Claimant's claim.

ORDER

It is therefore ordered that:

Claimant's claim for benefits under the Workers' Compensation Act of Colorado is denied and dismissed.

DATE: January 22, 2010

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-773-189

ISSUES

- Whether Claimant has developed a compensable occupational disease in her right shoulder;
- Whether Claimant is entitled to medical treatment for the occupational disease; and
- Whether Claimant is entitled temporary total disability (TTD).

FINDINGS OF FACT

1. Claimant worked for Employer as a trim sort operator beginning on January 7, 2008. Claimant's job required her to remove a wooden pallet from a stack of pallets approximately six to seven times per hour. The stack of pallets could reach a height at or above the Claimant's head, which could require Claimant to reach slightly above her head with her arms a few times each work shift. Claimant would continue to remove pallets from the stack until it reached the ground. She would then start pulling pallets from a new stack. The pallets weighed approximately seven pounds.
2. After Claimant pulled a pallet off of the stack with her arms, she would kick or push the pallet with her feet and legs over to another area approximately four feet away.
3. According to a DVD showing the job duties of a trim sort operator, the operator stands on a step stool near a large container which is being filled by pieces of fat falling from an opening in the ceiling directly above the container. The operator uses a long hook to reach into the container and pick out pieces of meat and carry them to another container. This part of the job does not require the operator to reach out or above shoulder level; however, she does reach down slightly into the container to pull out the meat.
4. The operator also has to place empty cardboard containers ("combo") weighing approximately three pounds onto the pallet. The operator then places a large empty

plastic bag into the combo. This duty requires lifting the arms at about shoulder level depending upon the height of the operator. In addition, the operator has to pull wooden pallets with her upper extremities and push these with her foot over to the location of the chute opening.

5. Claimant's job as a trim sort operator required the use of her arms, but did not involve repetitive overhead lifting. Claimant's job required her to use her arms between 60 and 70 times per day when pulling pallets from the stacks, putting the combo under the chute, and putting the plastic liner into the combo. The job duties required Claimant to reach with her arms away from her body approximately every ten minutes of each hour for eight hours each day.

6. In terms of characterizing weight as heavy or light, Claimant considered the weight of the combo, which weighs three pounds, to be "heavy." She also feels that the pallets, which weigh seven pounds, are heavy.

7. Claimant first sought treatment for her right shoulder pain at Salud Clinic on August 6, 2008. She reported to the physician's assistant ("PA") that she had developed pain in her right shoulder and arm which had been present for the last ten years, but had worsened over the last month. The PA further noted that Claimant "reports that she has had such symptoms for 10 years and they are not new specific to her work. She tells me they are aggravated over the last month or so." Claimant disputes that she reported to the PA that she had pain in her shoulder for 10 years.

8. Claimant returned to Salud on August 27, 2008, and reported to the PA that her other symptoms had resolved and that she only had shoulder pain which started only while working for the Employer. She further reported that the pain does not occur except when she performs her job duties and that she did not have this specific type of pain until she started working for Employer.

9. On October 3, 2008, Claimant returned to the Salud PA, who noted that he felt the Claimant clarified the reason for her shoulder pain complaints. She reported that it was due to the repetitive work she does for the Employer and that the pain started only when she started working for Employer.

10. Claimant also sought treatment with Employer's "in house" medical providers beginning on August 20, 2008. Among other complaints, Claimants reported pain in her right shoulder from "moving fat combos." On August 27, 2008, Claimant returned to the Employer medical staff and reported that lifting pallets day after day made her right shoulder injury worse.

11. Claimant began seeing Dr. Robert Thiel on September 4, 2008. Dr. Thiel noted that Claimant's job required her to lift up a piece of equipment that weighs seven pounds, carry it about four feet and set it down, which she had been doing for about eight months. Dr. Thiel noted that in her statement of injury, Claimant reported that "lifting heavy things repeatedly" caused her shoulder pain.

12. Claimant was placed on restrictions around this time and Employer placed her into a different job to accommodate the restrictions.

13. Claimant underwent an MRI study of her right shoulder which revealed a congenital condition called os acromiale, which is a condition where the tip of the shoulder blade is not fused.

14. Dr. Thiel referred Claimant to Dr. Kenneth Keller for an orthopedic evaluation in December 2008. Claimant reported to Dr. Keller that she had been pushing large pal-

lets which caused her to develop right shoulder pain. She also reported shoulder pain with "activity requiring the arm to be up in the air for repetitive activities and for a prolonged period of time." Dr. Keller noted that Claimant had positive rotator cuff signs and pain with internal and external rotation in the abducted position.

15. Claimant returned to Dr. Keller on January 5, 2009. At that time that she was tolerating her modified work duties except when working with her arm away from her body. Dr. Keller restricted Claimant from repetitive reaching away from the body, no work at or above the shoulder level, and he instructed her to avoid cold environments to minimize pain.

16. Claimant reported to more than one physician that her pain was worse in cold environments and at night.

17. After receiving an injection and physical therapy, Dr. Keller recommended that Claimant undergo surgery to repair the os acromiale. Claimant requested a second opinion because she did not want surgery at that time.

18. Dr. Thiel then referred Claimant to Dr. Philip Stull for a second opinion. Claimant first saw Dr. Stull on January 28, 2009. Claimant reported six months of right shoulder symptoms as a result of overuse and repetitive work lifting the arm. Dr. Stull found mildly positive impingement signs upon physical exam.

19. After reviewing the Claimant's MRI and the radiologist's report, Dr. Stull assessed Claimant with a symptomatic os acromiale. The MRI showed no internal derangement of the shoulder joint.

20. Claimant returned to Dr. Stull on April 23, 2009. He noted that Claimant had tenderness over the acromion, but had full range of motion of the shoulder and no other notable findings. Dr. Stull noted that he felt strongly that Claimant had a symptomatic os acromiale.

21. On May 8, 2009, Dr. Stull authored a letter to Dr. Thiel wherein he opined that Claimant's os acromiale is a congenital issue which became symptomatic due to work-related phenomenon and trauma, such as repetitive stress. Dr. Stull did not explain what he meant by "repetitive stress."

22. On May 22, 2009, Dr. Stull wrote another letter to the claims adjuster in which he opined that Claimant's os acromiale became symptomatic due to chronic stress from repetitive overhead lifting for many years. Dr. Stull opined that Claimant's symptoms are related to her work activities.

23. The Respondent referred Claimant for an independent medical examination with Dr. Lawrence Lesnak. Dr. Lesnak examined the Claimant on September 16, 2009. He also reviewed her medical records and the DVD referenced above. Dr. Lesnak concluded that Claimant had a possible symptomatic right os acromiale and clinical evidence of diffuse upper extremity ligamentous joint laxity to a moderate degree. Dr. Lesnak agreed with Dr. Stull that most individuals who have os acromiale exhibit no symptoms, but can occasionally become symptomatic with repetitive heavy overhead activities. Dr. Lesnak also felt that Claimant's symptoms may be due to the ligamentous joint laxity. Dr. Lesnak opined that no matter the anatomic cause of Claimant symptoms, neither were related to or caused by Claimant's work duties.

24. At hearing, Dr. Lesnak explained that in order for the os acromiale to become symptomatic, an individual must perform activities which are both overhead and repeti-

tive. He explained that the os acromiale causes an impingement when the fragment on the shoulder blade slides during the overhead activities.

25. No credible or persuasive opinion was offered to contradict Dr. Lesnak's opinion that in order for the os acromiale to become symptomatic, an individual would need to engage in repetitive overhead lifting. Here, there is no persuasive evidence that Claimant's job duties required her to engage in repetitive overhead lifting. At best, Claimant raised her arms to shoulder height or just above shoulder height occasionally throughout the work shift.

26. Based on the foregoing, Claimant has not established that she developed an occupational disease to her right shoulder. While Claimant believes the work she performed was repetitive and heavy as she reported to Drs. Stull and Keller, there is no persuasive evidence that her job required her to perform repetitive, heavy or overhead lifting.

CONCLUSIONS OF LAW

8. The purpose of the "Workers' Compensation Act of Colorado" is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. Section 8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. Section 8-43-201, C.R.S.

9. The ALJ's factual findings concern only evidence that is dispositive of the issues involved; the ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

10. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 57 P.2d 1205 (Colo. 1936); CJI, Civil 3:16 (2005).

11. A claimant must prove by a preponderance of the evidence that his injury arose out of the course and scope of his employment with employer. *Section 8-41-301(1)(b), C.R.S.; see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). An injury occurs "in the course of" employment where claimant demonstrates that the injury occurred within the time and place limits of his employment and during an activity that had some connection with his work-related functions. *See Triad Painting Co. v. Blair*, 812 P.2d 638 (Colo. 1991). The "arise out of " requirement is narrower and requires claimant to show

a causal connection between the employment and injury such that the injury has its origins in the employee's work-related functions and is sufficiently related to those functions to be considered part of the employment contract. *See Id.*

12. "Occupational disease" is defined by §8-40-201(14), C.R.S. (2002), as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

13. This section imposes additional proof requirements beyond that required for an accidental injury by adding the "peculiar risk" test; that test requires that the hazards associated with the vocation must be more prevalent in the work place than in everyday life or in other occupations. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. *Id.* A claimant is entitled to recovery only if the hazards of employment cause, intensify, or, to a reasonable degree, aggravate the disability for which compensation is sought. *Id.* Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Id.* Once claimant makes such a showing, the burden shifts to respondents to establish both the existence of a non-industrial cause and the extent of its contribution to the occupational disease. *Cowin & Co. v. Medina*, 860 P.2d 535 (Colo. App. 1992).

14. It is undisputed that Claimant has an os acromiale, a congenital condition not caused by her work activities. The issue is whether Claimant's job duties intensified or aggravated this underlying condition to produce the need for treatment. As found, both Drs. Keller and Stull concluded that Claimant's pain complaints were due to the os acromiale becoming symptomatic. Dr. Stull opined that Claimant's os acromiale became symptomatic because she engaged in repetitive overhead work duties; however, there is no credible or persuasive evidence that Claimant engaged in repetitive overhead activities at work. Accordingly, Dr. Stull's ultimate opinion that Claimant has developed a symptomatic os acromiale due to her work activities is unpersuasive. The Judge acknowledges that Claimant used her arms to perform her work duties, however, the evidence shows that these activities were not performed above her head. Dr. Lesnak testified that the os acromiale only becomes symptomatic when an individual engages in repetitive overhead activities. Claimant presented no credible evidence to contradict Dr. Lesnak's testimony as to the reasons an os acromiale becomes symptomatic. Thus, Claimant has failed to establish that her work activities caused her os acromiale to become symptomatic or that she otherwise developed an occupational disease in her right shoulder.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation is hereby DENIED and DISMISSED.
2. Because the claim is denied, the Judge need not address the remaining issues endorsed for hearing.

DATED: January 22, 2010

Laura A. Broniak
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-767-713

ISSUE

Whether Claimant has established by a preponderance of the evidence that he is entitled to recover penalties against Respondents pursuant to §8-43-304(1), C.R.S. for the failure to make payments pursuant to the parties' Settlement Agreement within a reasonable period of time.

FINDINGS OF FACT

1. On April 2, 2008 Claimant was infected with chicken pox while caring for a patient during the course and scope of his employment for Employer.

2. On October 2, 2008 Claimant filed an Application for Hearing endorsing the issue of penalties against Respondents for failure to: (1) report the injury/illness to Insurer; (2) timely report the injury/illness to the DOWC and; (3) admit or deny liability. Claimant also filed a separate bad faith claim against Respondents in an attempt to recover additional benefits for his chicken pox infection.

3. In order to avoid the expense and uncertainty of litigation, the parties entered into a Settlement Agreement in which Respondents collectively agreed to pay Claimant $17,000. Respondents agreed that Insurer would be responsible for $5,000 of the total settlement amount and Employer would be responsible for paying the remaining $12,000 of the settlement amount.

4. Paragraph 11 of the Settlement Agreement provided that Claimant "authorizes Respondents to send the settlement check directly to Claimant's attorney." The Settlement Agreement did not include a specific deadline for Respondents' payments to Claimant.

5. On June 19, 2009 the DOWC issued an Order approving the Settlement Agreement.

6. Insurer made its $5,000 payment to Claimant immediately after the Order was signed. Claimant has not asserted a penalty claim involving the $5,000 check issued by Insurer.

7. Insurer used third-party administrator Specialty Risk Services (SRS) to adjust insurance claims. SRS Claims Adjuster Kelly Thompson testified at the hearing in this matter. Ms. Thompson credibly stated that there was significant confusion as to who would pay the remaining $12,000 pursuant to the Settlement Agreement. Specifically, Ms. Thompson commented that she typically was not involved in cases in which there was separate counsel for both the employer and the insurance company. She was not aware of who would send out the $12,000 check from Employer and assumed someone else would be taking care of the matter. Based on the confusion, Employer's $12,000 settlement check was not immediately sent to Claimant.

8. Ms. Thompson remarked that she was made aware of the issue as to who would pay the $12,000 settlement check and started investigating the matter in early July of 2009. She noted that numerous supervisors made the decision as to how the $12,000 would be paid. Ms. Thompson ultimately received notice of approval to send out the check on July 13, 2009 and immediately requested the check.

9. Employer's counsel received a settlement check in the amount of $12,000 from Ms. Thompson and mailed the check to Claimant's counsel on July 20, 2009. Claimant's counsel acknowledged that the $12,000 check was sent to her office on Monday, July 20, 2009 and she received it on Tuesday, July 21, 2009.

10. On July 21, 2009 Claimant filed an Application for Hearing endorsing the issue of penalties. Specifically, Claimant sought penalties pursuant to §8-43-304, C.R.S. for Employer's failure to pay in accordance with the June 19, 2009 Settlement Order.

11. The DOWC issued an Order approving the Settlement Agreement on June 19, 2009. Thirty days from June 19, 2009 was July 19, 2009. However, because July 19, 2009 was a Sunday, July 20, 2009 was 30 days from the date the Settlement Order was issued.

12. Because Employer mailed the $12,000 settlement check to Claimant's counsel on July 20, 2009, Employer paid its portion of the Settlement Agreement within 30 days of the Order approving the Settlement Agreement. Based on the relevant statute, Rules and case law, 30 days constituted a reasonable time for Employer to pay its portion of the Settlement Agreement to Claimant. Therefore, Claimant has failed to establish that it is more probably true than not that Employer's disputed conduct violated a provision of the Act or a Rule. Claimant's request for penalties is thus denied.

CONCLUSIONS OF LAW

1. The purpose of the “Workers’ Compensation Act of Colorado” (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge’s factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2007).

4. Section 8-43-304(1), C.R.S. is a general penalty provision under the Act that authorizes the imposition of penalties up to $500 per day where a party violates a statute, rule, or lawful order of an ALJ. *Holliday v. Bestop, Inc.,* 23 P.3d 700, 705, 706 (Colo. 2001). The term “order” as used in §8-43-304 includes a rule or regulation promulgated by the Director of the DOWC. §8-40-201(15), C.R.S.; *see Spracklin v. Industrial Claim Appeals Office,* 66 P.3d 176, 177 (Colo. App. 2002).

5. The imposition of penalties under §8-43-304(1) requires a two-step analysis. *See In re Hailemichael,* W.C. No. 4-382-985 (ICAP Nov. 17, 2004). The ALJ must first determine whether the disputed conduct violated a provision of the Act or a Rule. *Allison v. Industrial Claim Appeals Office,* 916 P.2d 623, 624 (Colo. App. 1995). If a violation has occurred, penalties may only be imposed if the ALJ concludes that the violation was objectively unreasonable. *Colorado Compensation Insurance Authority v. Industrial Claim Appeals Office,* 907 P.2d 676, 678-79 (Colo. App. 1995). The reasonableness of an insurer’s actions depends upon whether the action was predicated on a “rational argument based on law or fact.” *In re Lamutt,* W.C. No. 4-282-825 (ICAP, Nov. 6, 1998).

6. Section 8-43-401(2)(a), C.R.S. provides the following standard for payments due pursuant to an order:

> After all payments have been exhausted or in cases where there have been no appeals, all insurers and self-insured employers shall pay benefits within thirty days of when benefits are due.

7. WCRP Rule 5-6(A) also reflects that 30 days is the proper time frame for making payments pursuant to an order:

> Benefits awarded by order are due on the date of the order. After all appeals have been exhausted or in cases where there have been no appeals, insurers shall pay benefits within thirty days of when the benefits are due. Any ongoing benefits shall be paid consistent with statute and rule.

8. Although §8-43-401(2)(a), C.R.S. and WCRP Rule 5-6(A) do not specifically apply to settlement agreements, the 30 day time period recognized in the statute and the Rule reflect that 30 days constitutes a reasonable period of time for the payment of benefits. Moreover, the Industrial Claim Appeals Panel (ICAP) has recognized that 30 days from the date of the order approving a settlement agreement constitutes a reasonable period of time for the payment of benefits. In *Mackins v. Pete Lien & Sons, Inc.*, W.C. No. 4-320-228 (ICAP, Oct. 13, 2000), the ICAP determined that an ALJ did not err in concluding that 30 days from the date a settlement agreement was finalized constituted a reasonable period of time to make a payment pursuant to the agreement.

9. WCRP Rule 1-2 provides that "Computation of days is consistent with Rule 6 of the Colorado Rules of Civil Procedure." Rule 6 of the C.R.C.P states "last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a legal holiday." As a result, if 30 days from the date of the order approving a settlement check falls on a Saturday or Sunday, the settlement check is not due until the following Monday.

10. If payment by mail is expressly directed or implicitly authorized by a claimant, the time of delivery is the time that the payment, properly addressed with postage prepaid, is placed in the mail. *Werne v. Brown,* 955 P.2d 1053 (Colo. App. 1998); *Jones v. Duckwall Alco Stores, Inc.,* W.C. No. 4-430-994 (ICAP, Mar. 28, 2003).

11. As found, the DOWC issued an Order approving the Settlement Agreement on June 19, 2009. Thirty days from June 19, 2009 was July 19, 2009. However, because July 19, 2009 was a Sunday, July 20, 2009 was 30 days from the date the Settlement Order was issued.

12 As found, because Employer mailed the $12,000 settlement check to Claimant's counsel on July 20, 2009, Employer paid its portion of the Settlement Agreement within 30 days of the Order approving the Settlement Agreement. Based on the relevant statute, Rules and case law, 30 days constituted a reasonable time for Employer to pay its portion of the Settlement Agreement to Claimant. Therefore, Claimant has failed to establish by a preponderance of the evidence that Employer's disputed

conduct violated a provision of the Act or a Rule. Claimant's request for penalties is thus denied.

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ORDER

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant's request for penalties against Respondents is denied and dismissed.

2. Any issues not resolved in this Order are reserved for future determination.

DATED: January 25, 2010.

Peter J. Cannici
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-633-179

ISSUE

The issue for determination is permanent partial disability (PPD) benefits – scheduled or whole person.

FINDINGS OF FACT

1. Claimant is employed by Employer as an all purpose food clerk and has worked there since 1999. Claimant's job duties included the unloading of merchandise from pallets and stocking shelves. This required Claimant to engage in extensive overhead activity.

2. As a result of the duties of her employment, Claimant began to experience a burning sensation in the area of her shoulders. Claimant reported the onset of an occupational disease on August 14, 2004.

3. An MRI arthrogram was conducted on October 4, 2004. The MRI showed loose bodies in the posterior-inferior aspect of Claimant's right shoulder joint.

4. On November 16, 2004, Claimant underwent a right shoulder arthroscopy with chondroplasty of the glenoid, chondroplasty of the humeral head, excision of loose carti-

laginous pieces and arthroscopic-assisted subacromial bursectomy. The surgery was performed by Dr. Jeffery Holtgrewe.

5. On January 6, 2005, an MRI of Claimant's left shoulder was obtained and revealed multiple intraarticular calcific bodies lining the subcoracoid recess, bicipital tendon tendinosis, mild tendinosis subscapularis, and some partial articular surface tearing of the supraspinatus.

6. On February 24, 2005, Claimant underwent left shoulder surgery which included: video arthroplasty, left shoulder debridement chondroplasty of the glenoid, grade 3-4 changes, debridement chondroplasty of the humeral head, grade 3-4 changes, synovitis, with partial synovectomy, loose body excision and subacromial bursectomy.

7. On November 18, 2005, Claimant received Visco supplementation injections in her bicipital groove.

8. On May 2, 2006, Claimant received a left shoulder Hemi Cap shoulder resurfacing procedure that was performed by Dr. Holtgrewe.

9. Claimant received a right shoulder Hyalgan injection on September 21, 2005, that was performed by Dr. Holtgrewe. Claimant also received a Hyalgan injection on September 28, 2005, to her left shoulder.

10. On November 2, 2006, Claimant underwent a left total shoulder arthroplasty, which is also known as a shoulder replacement.

11. Claimant was placed at maximum medical improvement (MMI) post left total shoulder arthroplasty and right shoulder arthroscopy on October 4, 2007. Subsequently, Claimant attended a DIME with Dr. Joseph Fillmore, who determined in his report of March 17, 2008, that Claimant was not at MMI. Dr. Fillmore recommended Claimant receive further evaluation of her right shoulder.

12. Claimant then was reevaluated by Dr. David Schneider, who recommended and performed a right total shoulder arthroplasty on September 30, 2008. The surgery is consistent with Claimant's work-related injury. Dr. Nordin concurred with Dr. Schneider's surgical recommendation.

13. Claimant was placed at MMI on March 13, 2009, and was re-evaluated by Dr. Fillmore, the Division independent medical examiner (DIME). In his report dated July 20, 2009, Dr. Fillmore concluded that Claimant was at MMI and issued a 45% whole person rating.

14. Dr. Fillmore also commented that Claimant's permanent work restrictions should entail no reaching overhead and no lifting overhead. These restrictions are consistent with Claimant's restrictions throughout the course of her claim as demonstrated by Dr.

Nordin's reports. Dr. Nordin previously commented that, based on the results of a FCE, claimant "should avoid all overhead lifting."

15. Dr. Nordin further commented that "[Claimant's] range of motion is fairly limited in both shoulders. She is not able to lift either arm much above shoulder height."

16. The physical therapy notes demonstrate that Claimant noted pain and difficulty with pulling her hair back during treatment, and lists aggravating factors as lifting overhead, outwards movement of the shoulder, and dressing.

17. Claimant testified regarding her limitations in performing daily activities as a result of her bilateral shoulder replacement surgeries:

> It's hard for me to get dressed. It's hard for me to take off my clothes, anything that I have to pull over my head, brushing my hair, taking a shower, washing my hair, any type of cleaning, anything away from my body -- I have to reach away from my body. (Hearing Transcript pg 27).

18. On July 11, 2007, Claimant was evaluated by Dr. Nicholas Olsen. He stated in his report that aggravating factors include reaching overhead. Pain charts filled out by Claimant illustrate Claimant's pain complaints as encompassing both shoulders with the pain spanning across and down her back.

19. At hearing Claimant described her current pain symptoms as going "from my neck down to my shoulder. I have it in my back. I have it between my shoulder blades." Claimant's description of her pain is consistent with and substantiated by the medical record. Claimant testified and demonstrated that she cannot lift her arms past her shoulders.

20. Claimant testified that she experiences an increase of pain down her neck and straight down her back when she attempts to lift her arms above her shoulders or when she extends her arms away from her body. Claimant testified that she experiences increased pain when pushing objects or pulling things down.

21. Claimant is currently working for Employer within her permanent work restriction of no overhead activity. Claimant uses a step stool that enables her to perform her job duties without having to lift overhead. Claimant testified that she experiences an increase of pain in her back and shoulders subsequent to a day at work to the extent where it disturbers her sleep.

22. Dr. Lawrence Barton Goldman, an expert in physical medicine and rehabilitation, testified at hearing. Dr. Goldman played an advisory role in the development of the accreditation and re-accreditation ratings courses, he is an associate editor of the accreditation curriculum, and had an advisory role at the Division of Workers' Compensation in

the implementation of various policies and rules that govern the impairment rating process and the application of the AMA Guides, Third Edition, Revised.

23. Dr. Goldman testified that from an anatomic approach, a kinesiologic approach, a functional approach, and a neuromuscular approach, in his opinion the Claimant's overall condition "comes as close to a whole person conversation from a medical perspective on all those different realms as any case I've reviewed or treated."

24. Dr. Goldman testified that it is expected that Claimant would experience pain in her back and neck as she attempts to perform overhead activities. Dr. Goldman explained that Claimant's pain would be "absolutely anticipated in terms of how the shoulder and the body works together that if you're dealing with two injured shoulders, you're going to be over-recruiting the midback muscles, the lower trapezius, the middle trapezius, the latissimus, the trapezius, in a way that's typically not anticipated for individuals who do not have injured shoulders."

25. Dr. Goldman testified upon witnessing Claimant attempting to lift her arms above her shoulders that: "It was very apparent that when she was lifting one shoulder, the other side of the body, including the trunk, was having to be recruited to help stabilize the shoulder and vice versa. There was over-recruitment of her trapezius, the muscles going up towards the neck. There was discoordination in terms of how the shoulder blades were working. And that's pretty common with the shoulder replacement surgeries."

26. Dr. Goldman explained that during the shoulder replacement surgeries, the surgeons cut through the fascia creating a scar between the deltoid and pectoralis muscle, which separates the fascial connection between those muscles resulting in a lack of coordination as Claimant attempts to push objects in front of her. This correlates to over-recruitment of muscles in the chest, trunk, and anterior neck in order to make up for the lack of the connection between the deltoid and pectoralis, resulting in pain symptoms.

27. Dr. Goldman clarified that Claimant's pain complaints in her back and neck as a result of the use of her shoulders are due to the loss of proprioception, as the nerve endings which operate Claimant's shoulder were sacrificed in her shoulder surgeries. As a result, Claimant experiences the over-recruitment of the trapezius in order to stabilize the shoulder.

28. In conclusion, Dr. Goldman stated that Claimant is entitled to a whole person rating associated with her bilateral shoulder injuries. The opinions of Dr. Goldman are credible and more persuasive then the opinions to the contrary.

CONCLUSIONS OF LAW

1. Evidence of pain and discomfort beyond the arm may support a finding of functional impairment to the whole person, where the pain or discomfort limits a claimant's use of a portion of the body beyond the arm. *Wiersema v High Valley Environmental,*

Inc., W.C. No. 4-178-272, (ICAO, March 28, 1997). Evidence of pain in a claimant's shoulders, chest and neck which limited movement of the claimant's shoulder joint was sufficient to support the ALJ's finding of functional impairment of the whole person. *Id.* In *Weirsema*, the ALJ credited evidence that showed the claimant has pain upon movement of his entire shoulder girdle resulting in his inability to perform overhead work as persuasive in determining that the claimant suffered a functional impairment beyond the arm. *Id.*

2. The extensive medical record evidencing Claimant's pain in her shoulders, upper back, neck, and trapezius is sufficient to support the finding of the whole person conversion. Furthermore, the evidence and testimony demonstrates that Claimant experiences an increase of pain in areas not found on the schedule of impairments when she attempts to perform overhead activities, activities which require her to extend her arms in front of her body, or activities which require pushing or pulling. Furthermore, due to pain and functional limitations, Claimant is unable to lift her arms above her shoulders, and has permanent work restrictions of no reaching or lifting overhead. The ALJ credits the testimony of Dr. Goldman in explaining the physiological impact of Claimant's bilateral shoulder replacements in concluding that the whole person conversion is appropriate.

3. Where the claimant suffers functional impairment that is not listed on the schedule, the claimant is entitled to medical impairment benefits for whole person impairment calculated in accordance with Section 8-42-107(8)(c), C.R.S. In the context of permanent partial disability, the term "injury" refers to the part or parts of the body which have been permanently, functionally impaired as a result of the injury, and not the physical situs of the injury. *Walker v Jim Fouco Motor Company*, 942 P.2d 1390 (Colo.App. 1997); *Langton v. Rocky Mountain Health Care Corp.*, 937 P.2d 883 (Colo.App. 1996). The term "injury" as used in Section 8-42-107(1)(a)-(b), C.R.S., refers to the part or parts of the body which have been disabled, not the situs of the injury itself or the medical reason for the ultimate loss. *Warthen v. Industrial Claim Appeals Office*, 100 P.3d 581 (Colo.App. 2004); *Strauch V. PSL Swedish Healthcare System*, 917 P.2d 366 (Colo.App. 1996).

4. Claimant's medical record and testimony clearly demonstrates that Claimant experiences pain in her shoulders, neck, back, deltoid, and trapezius as a result of her injuries and subsequent surgeries. Dr. Goldman credibly explained how Claimant's injuries and surgeries effect and disable parts of the body not listed on the schedule of impairments.

5. The determination of whether Claimant's injury falls within the schedule is a question of fact. *Strauch v. PSL Swedish Healthcare System, supra*.

6. Here, the facts, as contained in the medical reports, Claimant's testimony, and the testimony of Dr. Goldman, establish by a preponderance of the evidence that Claimant has suffered impairment not found on the schedule of impairments. Claimant's symptoms resulted from Claimant undergoing extensive treatment to both her

shoulders resulting in bilateral total shoulder joint replacements. As a result, Claimant is unable to perform overhead activities. Therefore, the facts presented at hearing support the whole person conversion, as the evidence demonstrates Claimant's disability in areas not found on the schedule of impairments.

ORDER

It is therefore ordered that Insurer shall pay Claimant permanent partial disability based on an impairment of 45% of the whole person. Insurer may credit any previous payments of permanent partial disability benefits. Insurer shall pay interest at the rate of eight percent of any benefits not paid when due.

DATED: *January 25, 2010*

Bruce C. Friend, ALJ
Office of Administrative Courts

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-773-899 & 4-796-131

ISSUES

Whether Claimant's claim in W.C. No. 4-773-899 should be re-opened on the basis of a change of condition.

Whether Claimant sustained a compensable injury on October 14, 2008 in W.C. No. 4-796-131.

Whether Claimant is entitled to an award of medical benefits, specifically, authorization and payment for a third MRI test requested by Dr. John Aschberger, M.D.

FINDINGS OF FACT

Based upon the evidence presented at hearing, the ALJ finds as fact:

1. Claimant sustained an admitted compensable injury to her low back on December 27, 2007 while employed by Employer. This injury is the subject of claim W.C. No. 4-773-899. At the time of this injury Claimant's job title was a residential coordinator for a facility that provides care for adults in an assisted living setting. On the date of injury Claimant was assisting a co-worker with transferring a resident into a wheelchair when she experienced a sharp and sudden onset of low back pain.

2. Following her injury of December 27, 2007 Claimant was referred to Concentra Medical Centers for evaluation and treatment. On March 27, 2008 Claimant was evaluated by Dr. Kirk Nelson, M.D. at Concentra and a diagnosis of Low back pain with

L5 radiculitis symptoms was given. Beginning in February 2008 Claimant came under the care of Dr. John Aschberger, M.D., a physical medicine and rehabilitation physician. Dr. Aschberger's treatment included a referral for an epidural steroid injection and a surgical consultation.

3. Claimant was evaluated by Dr. Aschberger on July 24, 2008 and reported that she was somewhat worse. Dr. Aschberger had reduced the dosage of the medication Lyrica and Dr. Aschberger believed that at least some of Claimant's increase in symptoms were due to the decrease in medication dosage. Dr. Aschberger delayed placement of Claimant at maximum medical improvement due to the increase in symptoms.

4. Dr. Aschberger again evaluated Claimant on August 11, 2008 and noted a report of symptoms in the right leg and foot. Dr. Aschberger recommended electrodiagnostic testing to evaluate these symptoms and again delayed placing Claimant at maximum medical improvement and assigning an impairment rating.

5. Claimant returned to Dr. Aschberger for evaluation on August 25, 2008 and at that time Dr. Aschberger reviewed the results of the diagnostic testing and found no acute abnormality and no indication of active lumbar radicular process. Dr. Aschberger noted that Claimant did not wish to proceed with surgery and he scheduled her for an impairment rating.

6. Dr. Aschberger placed Claimant at maximum medical improvement on September 11, 2008 for the December 27, 2007 injury and assigned 12% whole person impairment. Insurer filed a Final Admission of Liability dated October 17, 2008 admitting for 12% whole person impairment. At the time he placed Claimant at maximum medical improvement Dr. Aschberger recommended maintenance treatment consisting of continued use of the medication Lyrica and periodic physician follow-up visits to monitor the medication usage.

7. Following the injury of December 27, 2007 Claimant continued working for Employer. Prior to October 14, 2008 Claimant's job was changed from residential coordinator to "AM Team Lead"

8. On October 14, 2008 Claimant went to check on one of the residents and found the resident lying on the floor in the bathroom. Claimant called for assistance and then sat on the floor with the resident. Claimant then attempted to move or slide the resident away from the wall so that it would be easier to lift the resident. As Claimant did this she experienced a sudden, sharp pain in her low back in the same general area of the back where she had experience pain after the December 27, 2007 injury. Claimant reported the injury to Employer and was referred to Concentra Medical Center for evaluation and treatment.

9. Dr. Jan Updike, M.D. evaluated Claimant at Concentra on October 14, 2008. Dr. Updike noted complaint of pain in the lumbar region of 8.5 on a scale of 1 to

10, with the pre-injury pain level being 6.5. Dr. Updike's assessment was mechanical low back pain.

10. Claimant was evaluated by Dr. Nelson at Concentra on October 23, 2008 and he noted pain above the level of the patient's baseline. Dr. Nelson recommended Claimant pursue other employment given that her responsibilities included patient care.

11. Dr. Aschberger evaluated Claimant on November 13, 2008. Dr Aschberger noted that Claimant was continuing to report a lat of irritation in the back pain with radiation to the left leg from the exacerbation of her symptoms. Dr. Aschberger further noted that Claimant's range of motion was more restricted than when she had been placed at maximum medical improvement and that Claimant had increased complaints of pain and increased radiculitis. Dr. Aschberger recommended a repeat epidural steroid injection.

12. Dr. Aschberger evaluated Claimant on December 9, 2008. On that date Dr. Aschberger's assessment was "Chronic low back pain with an acute exacerbation and some increased radiculitis. Dr. Aschberger recommended a repeat or second MRI scan to rule out any objective deterioration in Claimant's lumbar spine.

13. At hearing, Dr. Aschberger testified, and it is found, that his recommendations in November and December 2008 for repeat epidural steroid injection and a second MRI scan were a direct reflection of the effects of the incident of October 14, 2008 when Claimant attempted to slide a resident on the floor.

14. Claimant testified that since the October 14, 2008 incident her low back pain is more constant, has a greater affect on her performance of activities of daily living such as caring for her grandchildren and that she had fewer good days with her back pain. The ALJ finds Claimant's testimony to be credible and it is found as fact. At an evaluation by Dr. Aschberger on January 13, 2009 he noted that Claimant had not improved symptomatically.

15. Claimant was evaluated by Dr. Aschberger on May 13, 2009. At that visit Claimant expressed to the physician some new concerns of loss of sensation for necessity of bowel movement, urinary urgency and occasional stress incontinence. Considering these symptoms and their progression Dr. Aschberger recommended a repeat or third MRI scan. Although this request was denied by Insurer, Dr. Aschberger testified at hearing, and it is found, that the repeat MRI is no longer necessary.

16. Claimant has proven by a preponderance of the evidence that she sustained a separate, compensable injury while working for Employer on October 14, 2008 in the nature of an aggravation of her pre-existing low back injury from December 27, 2007. The injury of October 14, 2008 necessitated additional medical treatment of a repeat epidural steroid injection and a second MRI scan that was different and distinct from the maintenance treatment Claimant was receiving for the December 27, 2007 injury.

17. Claimant has failed to prove by a preponderance of the evidence that she sustained a change in her low back condition that is a natural and direct result of the December 27, 2007 injury.

18. Claimant has failed to prove by a preponderance of the evidence that the MRI scan recommended by Dr. Aschberger on May 13, 2009 is a reasonable and necessary medical treatment at the present time.

CONCLUSIONS OF LAW

19. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

20. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

21. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

22. In order to recover benefits a claimant must prove that he sustained a compensable injury. A compensable injury is one which arises out of and in the course of employment. Section 8-41-301(1)(b), C.R.S. The "arising out of" test is one of causation. It requires that the injury have its origins in an employee's work-related functions. There is no presumption that an injury which occurs in the course of a worker's employment arises out of the employment. *Finn v. Indus. Comm'n,* 165 Colo. 106, 437 P.2d 542 (1968). It is the claimant's burden to prove by a preponderance of the evidence that there is a direct causal relationship between the employment and the injuries. *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989).

23. A pre-existing disease or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing disease or infirmity to produce a disability or need for medical treatment. *Duncan v. Industrial*

Claim Appeals Office, 107 P.3d 999 (Colo. App. 2004); *H & H Warehouse v. Vicory,* 805 P.2d 1167 (Colo. App. 1990). The question of whether the claimant met the burden of proof to establish a compensable injury is one of fact for determination by the ALJ. *City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985); *Faulkner v. Industrial Claim Appeals Office,* 12 P.3d 844 (Colo. App. 2000).

24. The mere occurrence of symptoms at work does not require the ALJ to conclude that the duties of employment caused the symptoms, or that the employment aggravated or accelerated any pre-existing condition. Rather, the occurrence of symptoms at work may represent the result of or natural progression of a pre-existing condition. *See F.R. Orr Construction v. Rinta,* 717 P.2d 965 (Colo. App. 1995)

25. Section 8-43-303(1), C.R.S., provides that an award may be reopened on the ground of, *inter alia*, change in condition. The claimant shoulders the burden of proving his condition has changed and his entitlement to benefits by a preponderance of the evidence. Section 8-43-201; *Berg v. Industrial Claim Appeals Office,* 128 P.3d 270 (Colo. App. 2005); *Osborne v. Industrial Commission*, 725 P.2d 63 (Colo. App. 1986). A change in condition refers either to change in the condition of the original compensable injury or to a change in the claimant's physical or mental condition that can be causally related to the original injury. *Jarosinski v. Industrial Claim Appeals Office,* 62 P.3d 1082 (Colo. App. 2002); *Chavez v. Industrial Commission,* 714 P.2d 1328 (Colo. App. 1985). The question of whether the claimant met the burden of proof to establish a causal relationship between the industrial injury and the worsened condition is one of fact for determination by the ALJ. *Cordova v. Industrial Claim Appeals Office*, 55 P.3d 186 (Colo. App. 2002); *City of Durango v. Dunagan, supra.* Similarly, the question of whether the disability and need for treatment were caused by the industrial injury or by an intervening cause or subsequent industrial injury is a question of fact. *Owens v. Industrial Claim Appeals Office, supra.*

26. Respondents are liable to provide medical treatment that is reasonable and necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), C.R.S. 2005. The question of whether the claimant proved treatment is reasonable and necessary is one of fact for the ALJ. *Kroupa v. Industrial Claim Appeals Office,* 53 P.3d 1192 (Colo. App. 2002).

27. As found, Claimant has proven that she sustained a separate, compensable injury to her low back on October 14, 2008. Although the injury is similar to and in the same general anatomical area as the previous injury of December 27, 2007, the incident of October 14, 2008 aggravated and accelerated Claimant's low back symptoms to the extent that she now required additional medical treatment of the type that was provided prior her being placed at maximum medical improvement for the December 27, 2007 injury. The ALJ finds and concludes that Claimant's injury of October 14, 2008 caused the need for medical treatment that was not part of the maintenance care she was receiving at the time for her December 27, 2007 injury. Although Claimant had experienced some flare-ups in her condition prior to being placed at maximum medical improvement, these flare-ups or exacerbations were not related to a specific event or

activity. After the October 14, 2008 incident Claimant's symptoms changed as a result of a sudden increase in symptoms that was directly related to Claimant's attempt to move a resident on that day.

28. The increase in Claimant's symptoms and change in her condition after October 14, 2008 were the result of Claimant's injury on that date and not as a natural and direct result of her previous December 27, 2007 injury. Claimant's change in condition occurred as the result of a specific work-related event that was not causally related to the December 27, 2007 injury. As found, Claimant has failed to sustain her burden of proof to re-open the December 27, 2007 claim.

29. As found, the third MRI recommended by Dr. Aschberger, and denied by Insurer, is no longer reasonable and necessary as established by the testimony of Dr. Aschberger at hearing. Therefore, Claimant has failed to sustain her burden of proof to obtain an award of medical benefits, specifically, the requested MRI. This conclusion would apply equally to either a finding that Claimant sustained a new compensable injury on October 14, 2008 or, in the alternative, if it were concluded that Claimant's December 27, 2007 injury should be re-opened.

ORDER

It is therefore ordered that:

1. Claimant's claim of injury to her low back on October 14, 2008 in W.C. No. 4-796-131 is compensable.

2. Claimant's Petition to Re-Open in W.C. No. 4-773-899 is denied and dismissed.

3. Claimant's claim for medical benefits, specifically authorization and payment for a third MRI scan, is denied and dismissed.

All matters not determined herein are reserved for future determination.

DATED: January 25, 2010

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-775-416

ISSUES

The sole issue determined herein is medical benefits.

FINDINGS OF FACT

1. Claimant was employed as a groundskeeper for the employer. He suffered previous low back problems and underwent a magnetic resonance image ("MRI") in 2003. He suffered a previous admitted work injury to his low back in September 2005. A December 13, 2005, MRI showed no significant changes from the 2003 MRI. Claimant was treated conservatively. On January 19, 2006, Dr. Polanco determined that claimant was at maximum medical improvement ("MMI") for the 2005 injury. Dr. Polanco imposed permanent restrictions for medium duty work, lifting to 50 pounds. Claimant then returned to his regular job for the employer.

2. In March 2008, claimant began working part-time as a delivery technician for Apria Healthcare in addition to his full-time job for the employer. For Apria, claimant loaded and unloaded medical equipment from a van or small truck, lifting to 25 pounds.

3. On July 28, 2008, claimant suffered an admitted work injury for the employer when he was raking the baseball field and suffered sharp low back and leg pain.

4. On July 28, 2008, Dr. Polanco examined claimant and prescribed physical therapy and work restrictions.

5. Claimant returned to work in modified duty for the employer and continued his work for Apria.

6. A September 10, 2008, MRI showed disc bulges causing S1 nerve root compression, left greater than right, without any significant changes from the December 13, 2005, study.

7. On September 25, 2008, the employer terminated claimant's employment.

8. On November 19, 2008, the insurer filed a general admission of liability for medical benefits.

9. Claimant continued to have episodic radicular symptoms and Dr. Polanco referred him to Dr. Sung for a surgical evaluation.

10. On December 3, 2008, Dr. Sung evaluated claimant and diagnosed degenerative disc disease with neural foraminal stenosis L4 to S1. He recommended a discogram.

11. The February 2, 2009, discogram showed concordant pain at L5-S1.

12. Commencing approximately December 15, 2008, claimant increased to approximately full-time work for Apria. He continued to work approximately 80 hours

every two weeks through March 8, 2009. He again worked approximately full-time for the pay period April 6-19, 2009.

13. On February 26, 2009, Dr. Sung reexamined claimant, who reported working part-time and having good and bad days. Dr. Sung noted that claimant had decided not to have surgery at that time.

14. On March 11, 2009, Dr. Polanco reexamined claimant and noted that he was stable and had declined surgery. Dr. Polanco recommended a home exercise program. On March 25, 2009, Dr. Polanco determined that claimant was at MMI, but still remained a surgical candidate.

15. On April 22, 2009, Dr. Polanco reexamined claimant, who reported a significant increase in low back and right leg pain. Dr. Polanco recommended physical therapy and an epidural steroid injection ("ESI"). On April 29, 2009, Dr. Polanco reexamined claimant, who was still suffering from the significant aggravation of his condition. Dr. Polanco noted that claimant did not suffer any new injury.

16. On May 6, 2009, Dr. Polanco administered a trigger point injection because he had not yet received approval from the insurer to do the ESI. On May 13, 2009, Dr. Polanco administered the ESI, which improved claimant's condition.

17. A May 14, 2009, MRI showed no changes from the 2008 MRI.

18. On May 21, 2009, Dr. Sung reexamined claimant, who reported a history of increased pain for a "few weeks." Dr. Sung recommended proceeding with the decompression and fusion surgery at L4-S1.

19. Dr. Polanco excused claimant from returning to work pending his surgery.

20. On June 30, 2009, Dr. Polanco noted that claimant had gradual improvement in symptoms, but still suffered right radicular symptoms.

21. On August 11, 2009, Dr. Fall performed an independent medical examination ("IME") for respondents. Dr. Fall noted 5/5 positive Waddell's signs, specifically pain with axial compression, pain with simulated rotation, superficial tenderness to palpation, distracted straight leg raise, and regional disturbance. Claimant had additional pain behaviors with low back pain with cervical range of motion and with shoulder abduction. Dr. Fall reported normal paraspinal muscle tone and diffuse tenderness throughout the thoracic and lumbar spine without any focal area of tenderness. Lumbar range of motion was measured and straight leg raising test was negative bilaterally. Examination findings were noted to be inconsistent between seated straight leg testing and supine testing. Dr. Fall further noted significant pain behaviors with Faber's maneuver and non-organic sensory findings on neurological examination. In summary, Dr. Fall reported that throughout the examination, claimant exhibited significant pain behaviors. Dr. Fall assessed pre-existing underlying degenerative lumbar spine condition

with no acute changes per MRI scans. Dr. Fall considered claimant to be at MMI and that he was a poor surgical candidate. She recommended a psychological evaluation.

22. By October 15, 2009, Dr. Polanco noted that claimant was substantially improved, but he suffered episodic radicular symptoms, for which he needed surgery.

23. On October 21, 2009, Dr. Sung responded in abbreviated fashion to a letter of inquiry and indicated that the surgery was reasonably necessary to treat the 2008 work injury and that claimant was a good candidate for surgery. Dr. Sung did not provide any further explanation.

24. Dr. Fall and Dr. Polanco testified by deposition consistent with their reports. Dr. Fall testified that the need for surgery, if it exists, would not be related to the work injury of July 28, 2008. Dr. Fall's opinion was based upon the mechanism of injury by raking, which did not involve significant trauma. According to Dr. Fall, this would account for a more muscular strain type of injury. Dr. Fall's opinion was also based upon the fact that there were no significant changes on claimant's lumbar spine MRI. There was no acute disc herniation following the work injury of July 28, 2008. Specifically, there was no change when comparing the September 10, 2008, MRI to the December 13, 2005, MRI. In addition, there was no change on the May 14, 2009 MRI. According to Dr. Fall, there was no acute change or structural change on MRI that would lead to the need for surgery.

25. Dr. Fall also based her conclusion on claimant's pain behaviors, which raise concern for nonorganic factors for the complaints of pain. Dr. Fall opined that claimant would be a poor surgical candidate based upon his nonphysiologic examination, his significant pain behaviors, and the "probable" psychosocial issues that were playing a role in his symptoms. Dr. Fall also testified that it was not clear that claimant was having symptoms from any nerve impingement so it would not make sense to treat his complaints of pain that did not correlate to findings on physical examination. Dr. Fall's testimony is corroborated by the negative straight leg raise test findings by Dr. Polanco on June 30, July 15, and August 5, 2009, and the mildly positive finding on the right side on August 26, 2009, which is inconsistent with claimant's previous complaints of pain radiating to his left leg.

26. Dr. Polanco disagreed with Dr. Fall's observations and conclusions. He did not understand Dr. Fall's description of nonphysiologic behaviors. He thought that claimant was psychologically stable and did not need any "counseling." He concluded that claimant has had slightly decreased motor nerve status, but it was not grossly observable. He noted that claimant's episodic radicular pain was associated with work activities, but he did not think that claimant suffered any aggravation in his "part-time" job. Dr. Polanco relied on the discogram results and Dr. Sung's recommendation for surgery.

27. Claimant has failed to prove by a preponderance of the evidence that the L4-S1 decompression and fusion surgery by Dr. Sung is reasonably necessary at this time to cure or relieve the effects of the July 28, 2008, work injury. The opinions of Dr. Fall are persuasive. Dr. Fall has explained claimant's numerous pain behaviors that

cause her to conclude that claimant is not a good surgical candidate. Dr. Polanco and Dr. Sung do not address those concerns. Dr. Fall has recommended a psychological evaluation before fusion surgery, as required by WCRP 17-7, Exhibit 1, F.4.d.v. Dr. Polanco is not persuasive that claimant is psychologically stable and does not even need a psychological evaluation.

CONCLUSIONS OF LAW

1. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). As found, claimant has failed to prove by a preponderance of the evidence that the requested surgery is reasonably necessary at this time to cure or relieve the effects of the admitted work injury.

ORDER

It is therefore ordered that:

1. Claimant's request for authorization of the L4-S1 decompression and fusion surgery by Dr. Sung is denied.

2. All matters not determined herein are reserved for future determination.

DATED: January 26, 2010

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-731-940

ISSUES

7. Whether or not the July 17, 2007 work-related injury to Claimant's back, caused Claimant to be unable to earn a wage in any capacity thereby rendering Claimant permanently and totally disabled?

8. In the event the July 17, 2007 work-related injury caused Claimant to be unable to earn a wage in any capacity, does apportionment apply regarding Claimant's pre-existing general health problems?

9. In the event the July 17, 2007 work-related injury caused Claimant to be unable to earn a wage in any capacity, does apportionment apply to Claimant's subsequent July 28, 2008 non work-related motor vehicle accident?

10. If Claimant is found, as a result of the subject work injury, to be unable to earn a wage in any capacity, are Respondents entitled to a retroactive and continued Social Security offsets.

11. If Respondents overpaid Claimant $5,364.80 in permanent partial disability benefits, are Respondents entitled to an overpayment of $5,364.80?

12. Is Claimant entitled to an additional disfigurement award?

II. STIPULATIONS

Claimant receives $611 in Social Security benefits that began on or around February 1996 and $96.40 in SI benefits for an offset amount of $707.40 in Social Security benefits.

FINDINGS OF FACT

21. Claimant injured himself on July 19, 2007, while an employee of the Respondent-Employer doing labor work in the horse stables. He was pushing a very heavy wheelbarrow up and over some two by fours. He had to push hard to get the wheelbarrow over a hole. He heard a pop in his back and developed low back pain. The pain radiated down his right buttock and leg which he described as severe and constant. He originally saw Dr. Kurish who referred him to Concentra Medical Centers. He then saw Dr. Baer who did an injection. A second injection gave him some relief. Ultimately, he saw Dr. Sung, a neurosurgeon, and had an L5-S1 wide decompression, L5-S1 anterior and posterior column arthodesis with screw implantation. Claimant believes he has "a lot of screws in his back."

22. He received care after the surgery, was placed at MMI and given a rating by his authorized treating physician, Dr. Hattem, and given permanent work restrictions that he not lift, push, pull objects weighing more than 5 pounds and that he be able to sit-stand as tolerable.

23. Claimant had a DIME performed by Dr. Finn who gave him a 15% whole person rating. He agreed with Dr. Hattem's MMI date of October 21, 2008.

24. Dr. Hattem and Dr. Finn collectively did not give Claimant any physical restrictions from his subsequent auto accident, nor did they apportion any impairment rating.

25. Claimant described his self-limitations as being able to sit or stand for about 15 minutes before his pain increases. He can walk short distances such as to his mailbox

and back. His walking tolerance is a slow pace for 5 to 6 minutes with a cane. He agrees with the lifting, push-pull restrictions imposed by Dr. Hattem. He is fatigued all the time because the pain he is in prohibits him from getting a good night's sleep. His daughter drives him if he has to go anywhere. He states he can't do laundry, grocery shopping, cleaning or any other household chores. He watches TV and reads the Bible most of the day.

26. Claimant is 75 years old with an 8th grade education from Puerto Rico. He speaks, reads, and writes Spanish. He speaks English; reads some English including the Bible and want ads, and can write very little English.

27. Claimant has been in the United States since the 1950's and has basically done hard physical labor; farm work, construction, factory, and the like. He also ran a small Spanish film theater from 1970 to 1973. From 1978 to the 1980's, he booked some Spanish bands into small Spanish dance halls in Michigan.

28. Claimant has had two felony convictions. Both were for drugs. He as in federal prison from 1984 to 1987 and 1992 to 1995.

29. Claimant has done mainly physical labor all of his life. Both of Claimant's entrepreneurial ventures ended in failure. His experience in the theater was about 35 to 40 years ago. His wife helped him in the theater. His experience booking bands was about 30 to 35 years ago. His partner ran off with his money. Claimant's bookkeeping experience was writing down what came in and depositing it. His math skills are limited. He has had no training in bookkeeping, data entry, use of ledgers, balancing books, and so on. Claimant's negotiation skills with booking bands consisted of getting a date at the local dance hall and then calling the band, usually in Texas, to come perform. His promotional skills consisted of putting up posters. Claimant believes there are no jobs he can do in light of his physical restrictions, job experience, job training, age, language skills, and other factors.

30. Bruce Magnuson was recognized as an expert in Vocational Rehabilitation. Mr. Magnuson opined that Claimant is permanently and totally disabled. His conclusion was that Claimant's age, past labor experiences, education, limited math skills, inability to write English, and his physical restrictions lead him to the determination that Claimant does not have any skills that would be currently compatible in any capacity with his residual functional capacity. He concluded Claimant is permanently and totally disabled.

31. Dr. Finn conducted the division independent medical evaluation (DIME) of the Claimant. Dr. Finn opined that Claimant's physical problems are related to his work injury and not anything else. He did not feel Claimant's pre-existing cardiac problems were the cause of Claimant's disability as he did heavy labor after a stent was implanted. He agreed with the physical restrictions. He did not agree that apportionment was appropriate under the circumstances.

32. Dr. Raschbacher testified for Respondents. His conclusion was that Claimant had a significant residual from the subsequent motor vehicle accident of July 28, 2008. Dr. Raschbacher gave Claimant lifting limits of 20 to 40 pounds. He did not find the ROM recently done or the care to be credible. He says the fact that Claimant flew to Puerto Rico after his surgery shows he can engage in something physically arduous.

33. Cynthia Bartmann testified for Respondents. In her vocational evaluation report, she states that the Claimant has basic experience taking inventory, bank deposits, light

bookkeeping, negotiating leases, cashier and customer service. She opined that the Motel 6, AARP Foundation, Ambassador Adult Theater, American Plan USA, AMPC Parking, and Holland Residential are all places where the Claimant could work.

34. The Claimant sustained a disfigurement to his body as a result of the work related injury consisting of a vertical surgical scar running down the middle of Claimant's back being ten inches in length and three-quarters of an inch in width. The Respondents' admitted for and paid a payment of $300.00 for disfigurement. The ALJ finds the Claimant is entitled to a total of $2,000.00 for disfigurement. The Respondents are entitled to a $300.00 credit towards the disfigurement award herein.

35. The ALJ finds Mr. Magnuson's opinions to be the more credible concerning Claimant's ability to earn a wage in any capacity and assigns greater weight to those opinions than to opinions to the contrary.

36. The ALJ finds Dr. Finn's opinions to be the more credible medical opinions concerning Claimant's medical condition and the relatedness of Claimant's condition to his industrial injury of July 17, 2007 and assigns greater weight to his opinions than to opinions to the contrary.

37. The parties' stipulated Claimant is receiving $707.40 per month in Social Security Benefits. The Claimant began receiving Social Security benefits on February 1996. As such, respondents are entitled to a retroactive Social Security disability offset.

38. On October 21, 2008, Dr. Al Hattem, M.D. assigned Claimant a 23% whole person impairment rating to Claimant's back. Thereafter, Claimant filed an Objection to the Final Admission of Liability and requested a Division IME. On March 16, 2009, Dr. Kenneth Finn, M.D. performed the Division IME. Dr. Finn agreed Claimant remained at medical maximum improvement but assigned Claimant a 15% whole person impairment rating.

39. On March 30, 2009, Respondents filed the Final Admission of Liability admitting to Dr. Finn's Division IME Report. Because Dr. Finn reduced Claimant's impairment rating, and because Respondents previously paid out to Claimant permanent partial disability benefits at 23% impairment rating, Respondents are entitled to recoup the overpayment from Claimant.

40. Respondent-Insurer has overpaid Claimant in the amount of $5,364.80 based upon the impairment rating provided by the ATP that was reduced by the DIME.

CONCLUSIONS OF LAW

13. Permanent Total Disability is defined by Section 8-40-201 (16.5)(a) as the Claimant's inability "to earn wages in the same or other employment." The burden of proof is on the Claimant to prove by a preponderance of the evidence that he is permanently and totally disabled. *Holly Nursing Care Center v. Industrial Claims Appeal Office*, 582 P.2d 701, (Cob. App. 1999). The ALJ may consider several human factors" in making the decision. The factors include, but are not limited to, the Claimant's physical condition, mental ability, age, employment history, education, and the availability of work the Claimant can perform. *Christie v. Coors Transportation Com-*

pany, 933 P.2d. 1330 (Cob. 1997) and *Weld County School District RE-12 v. Byner*, 955 P.2d. 550 (Cob. 1998).

14. An industrial injury does not need to be the sole cause of the Claimant's permanent and total disability. An employer takes the injured worker as it finds him and permanent total disability can be a combination of personal factors and a work-related injury. *Climax Molybdenum Co. v. Walter*, 812 P.2d. 1168 (Cob. 1991). Claimant has provided the most persuasive evidence that he is permanently and totally disabled and the July 19, 2007 industrial injury is a significant factor in his permanent and total disability.

15. Dr. Finn, the DIME doctor, felt the problems Claimant had were a result of the July 19, 2007 industrial accident. He did not feel Claimant's pre-existing cardiac problems were the cause of Claimant's disability as he did heavy labor after a stent was implanted. He agreed with the physical restrictions.

16. Dr. Hattem and Dr. Finn collectively did not give Claimant any physical restrictions from his subsequent auto accident, nor did they apportion any impairment rating.

17. In light of Claimant's age, language, math, and writing deficiencies, felony convictions, physical restrictions, and work experience Claimant has established by a preponderance of the evidence that he is permanently and totally disabled.

18. The court of appeals has affirmed the apportionment of permanent total disability benefits where the "disability" arises when the Claimant's baseline access to the labor market is reduced by injuries, illness, or aging processes. *Waddell v. Industrial Claim Appeals Office*, 964 P.2d 552, 554 (Colo. App. 1998); *Colorado Mental Health Institute v. Austil*, 940 P.2d 1125 (Colo.App. 1997).

19. In the case hereunder, the evidence is insufficient to establish that apportionment is required. Dr. Finn determined that apportionment was not an issue in his rating. Apportionment is an affirmative defense and the record does not establish by a preponderance of the evidence that apportionment is appropriate.

20. Based upon Claimant’s date of injury $4,000.00 is the maximum entitlement for disfigurement. The ALJ concludes that Claimant’s disfigurement establishes that an award of $2,000.00 is appropriate. The Respondents’ admitted for and paid a payment of $300.00 for disfigurement. The ALJ finds the Claimant is entitled to a total of $2,000.00 for disfigurement. The Respondents are entitled to a $300.00 credit towards the disfigurement award herein, leaving an amount due of $1,700.00.

21. The parties’ stipulated Claimant is receiving $707.40 per month in Social Security Benefits. The Claimant began receiving Social Security benefits on February 1996. As such, Respondents are entitled to a retroactive Social Security disability offset. The offset may be taken retroactively against previously paid workers' compensation disability benefits that should have been reduced in the first instance. Respondents are entitled to recover the "overpayment" of permanent disability benefits created by the retroactive Social Security award. *See* § 8-42-113.5, C.R.S. 2004; *Johnson v. Industrial Commission,* 761 P.2d 1140 (Colo. 1988).

22. C.R.S. §8-43-207(1)(q) provides “[h]earings shall be held to determine any controversy concerning any issue arising under articles 40 to 47 of this title. In connection with hearings, the director and administrative law judges are empowered to:

> (q) Require repayment of overpayments.

23. On October 21, 2008, Dr. Al Hattem, M.D. assigned Claimant a 23% whole person impairment rating to Claimant's back. Thereafter, Claimant filed an Objection to the Final Admission of Liability and requested a Division IME. On March 16, 2009, Dr. Kenneth Finn, M.D. performed the Division IME. Dr. Finn agreed Claimant remained at medical maximum improvement but assigned Claimant a 15% whole person impairment rating.

24. On March 30, 2009, Respondents filed the Final Admission of Liability admitting to Dr. Finn's Division IME Report. Because Dr. Finn reduced Claimant's impairment rating, and because Respondents previously paid out to Claimant permanent partial disability benefits at 23% impairment rating, Respondents are entitled to recoup the overpayment from Claimant in the amount of $5,364.80.

ORDER

It is therefore ordered that:

Respondents shall pay Claimant permanent total disability benefits as determined by law, including provisions for offsets and overpayments.

Respondents' claim for apportionment is denied and dismissed.

Respondents shall pay Claimant $2,000.00 for disfigurement, less the $300.00 previously paid for disfigurement resulting in a current award of $1,700.00.

Respondents are entitled to a repayment of benefits based upon the offset for social security benefits previously paid.

Respondents are entitled recoup permanent partial disability benefits paid to Claimant that are in excess of the amount required to have been paid pursuant to the DIME determination of PPD resulting in an overpayment of $5,364.80.

The insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATE: January 26, 2010

Donald E. Walsh
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-676-156

ISSUES

The following issues were raised for consideration at hearing:

1. Is Claimant entitled to medical benefits, specifically reimbursement for hotel lodging and food items from July 17, 2008, through August 21, 2008?

2. Is Claimant entitled to reimbursement for an orthotic prescribed by his treating physician?

FINDINGS OF FACT

Having considered the evidence presented at hearing, the following Findings of Fact are entered.

1. Claimant sustained a compensable injury to his right ankle on January 17, 2006. On May 7, 2008, he underwent a third surgery on his right ankle. Dr. Resig performed a right ankle arthroscopy with debridement of chondral lesion; removed hardware from the right ankle; performed open reduction and internal fixation for a fibular non-union of the right ankle, and a right tibia bone graft harvest. (Claimant's exhibit 6, pp.6-7).

2. Respondents provided lodging for Claimant at a Howard Johnson motel from May 7, 2008, to July 16, 2008, because his surgery prevented him from caring for himself in his motor home.

3. On July 17, 2008, Claimant continued to stay in his room at the Howard Johnson motel because he felt his ankle was not healed sufficiently for him to return home where he could not use his wheelchair. Claimant paid $1,360.00 for motel lodging to August 21, 2008. During this period Claimant also incurred food expenses of $376.79.

4. Claimant's home is a 35-foot, 1978-model motor home. His wheelchair, which was approximately 29 inches wide, could not be accommodated in Claimant's home. To enter the motor home Claimant must walk up stairs and go through a doorway 22 to 24 inches wide. The width of the bathroom is approximately 17 inches. There is a couch and table in the motor home with clearance of only 20 inches. Claimant does not have a working shower in his motor home and had to use a public shower at the RV Park, approximately 100 yards from his motor home over terrain consisting of rocks, gravel, steps, and hills, which was not accessible by wheelchair.

5. As of July 17, 2008, Claimant was still using his wheelchair and crutches. One of his treating physicians, Dr. Brodie, limited Claimant's mobility to using crutches 10% of the time and sitting 90% of the time. (Claimant's exhibit 4, p.4). Further, prior to undergoing this surgery, Claimant put his motor home into storage because the RV Park where he lives is not secure. Dr. Brodie's physical limitations prevented Claimant physically from being able to make his motor home habitable again by putting up the entry stairs to access his home and reconnecting the propane tank and sewer line.

6. Claimant's surgeon, Dr. Resig, reported July 15, 2008, that Claimant had started pool therapy to rehabilitate his right ankle. He also prescribed an orthotic for Claimant's shoe (Claimant's exhibit 6, p.10). Claimant purchased the orthotic recommended by Dr. Resig, a Birkenstock shoe insert, which cost $64.51. Respondent stipulated in its post hearing position statement that Claimant is entitled to reimbursement for the orthotic recommended by Dr. Resig and purchased by Claimant.

7. Physical therapy also was prescribed. In July 2008, Claimant's physical therapist taped his right foot and leg. As a result, Claimant sustained a severe latex allergy reaction and developed a large blister on his instep and the bottom of his right foot. Dr. Brodie noted on July 31, 2008 Claimant had a "significant rash and blistering on his foot." (Claimant's exhibit 7, p.19). Dr. Brodie referred Claimant to Dr. Goodman, who confirmed Claimant had contact allergic dermatitis to adhesive tape containing natural rubber latex, suggesting that Claimant "is at some increased risk for a more systemic (not simply skin-involving) reactivity to latex." (Claimant's exhibit 10, p.31). Dr. Brodie also reported only slow improvement from the right ankle revision arthrodesis, noting diffuse swelling about the ankle with restriction in range of motion and an antalgic gait. (Claimant's exhibit 7, pp. 20, 19). In addition, the walking boot caused bursitis in Claimant's right knee and Dr. Brodie recommended physical therapy for this. (Claimant's exhibit 7, p.20).

8. Claimant left the motel on August 21, 2008, because he could no longer afford to stay there. Reports from his treating physicians confirmed that Claimant still had disabling problems with his right ankle. Dr. Resig saw Claimant on August 12, 2008, but did not provide a release to full weight bearing. (Claimant's exhibit 6, p.14). On August 26, 2008, Dr. Brodie reported Claimant's right ankle continued to be swollen and sore to walk on. (Claimant's exhibit 7, p.26a). By September 9, 2008, Dr. Resig reported possible posterior impingement and moderate swelling of the ankle. (Claimant's exhibit 6, p.15). Two weeks later, on September 30, 2008, Dr. Resig prescribed an MRI because of concern of a symptomatic "os trigonum" causing symptoms. By October 30, 2008, Dr. Brodie confirmed Claimant had a failed fusion, and Dr. Resig had recommended an arthrodesis of the right ankle. (Claimant's exhibit 7, pp.22-23).

9. On September 30, 2008, Dr. Resig opined it was medically necessary for Claimant to spend an additional month in the motel until August 22, 2008, because of continuing ankle problems. (Claimant's exhibit 3, p.3).

10. Respondents contend an order entered July 9, 2008, by Judge Cannici applies to the issues presented to this Judge to deny reimbursement to Claimant for his motel lodging and food expenses. The prior order's denial of reimbursement for motel lodging and food expenses were for a specified period of time, August 9, 2007, to September 17, 2007, and made no determination as to future medical benefits. The facts here are different, and the issues are different. Accordingly, the doctrines of res judicata, law of the case and collateral estoppel are not relevant and do not apply

CONCLUSIONS OF LAW

Having made the foregoing Findings of Fact, the Following Conclusions of Law are entered.

1. The purpose of the "Workers' Compensation Act of Colorado", Title 8, Article 40 to Article 47, C.R.S., is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), C.R.S. Claimant has the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier of fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Section 8-43-201, C.R.S. A workers' compensation case is decided on its merits. Section 8-43-201, C.R.S.

2. The ALJ's factual findings concern only evidence that is dispositive of the issues involved. The ALJ has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. Industrial Claim Appeals Office*, 5 P.3d 385 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witnesses' testimony and actions, the reasonableness or unreasonableness (probability or improbability) of the testimony and actions, the motives of the witness, whether the testimony has been contradicted, and bias, prejudice or interests. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936).

4. Respondents are liable for authorized medical treatment that is reasonable and necessary to cure and relieve the effects of an industrial injury. Section 8-42-101 (1) (a), C.R.S.; *Colorado Compensation Insurance Authority v. Nofio*, 886 P.2d 714, 716 (Colo. 1994). Employers have thus been required to provide services that are either medically necessary for the treatment of a claimant's injuries or incidental to obtaining treatment. *In Re Robertson*, W.C. No. 4-389-907 (ICAP, Jan. 10, 2007).

5. An expense is incidental to medical treatment if it "enables" the claimant to receive treatment. *In Re Mitchell*, W.C. No. 4-312-227 (ICAP, Oct. 21, 1997). Incidental expenses include room and board where the claimant is required to be away from home to access prescribed medical treatment. *Industrial Commission v. Pacific Employers Insurance Co.*, 120 Colo. 273, 209 P.2d 908 (1949), see *In Re Mitchell*, W.C. No. 4-312-227 (ICAP, Oct. 21, 1997). Incidental expenses are thus not compensable unless they would not have been incurred but for the industrial injury. *In Re Kuziel*, W.C. No. 4-139-839 (ICAP, Nov. 8, 1995). The determination of whether a specific expense is incidental to obtaining medical treatment is a question of fact for the ALJ. *In Re Mitchell*, W.C. No. 4-312-227 (ICAP, Oct. 21, 1997).

6. Claimant has established by a preponderance of the evidence that he is entitled to reimbursement in the amount of $376.79 for food expenses and $1,360.00 for lodging expense that he incurred while living in a motel from July 17, 2008, to August 21, 2008. Claimant was required to reside in the motel beginning on May 7, 2008, because his right ankle surgery prevented him from caring for himself in his motor home. Claimant's lodging and food expenses while at the motel incurred during the period July 17, 2008, to August 21, 2008, were incidental to his industrial injury because they would not have been incurred but for the industrial injury.

7. In this regard, concerning Claimant's entitlement to reimbursement for food expenses and lodging from July 17, 2008, to August 21, 2008, it was established through Claimant's credible testimony and the medical records.

8. Respondents concede that Claimant is entitled to reimbursement for his Birkenstock "orthotics."

9. Respondents contend an order entered July 9, 2008, by Judge Cannici applies to the issues presented to this Judge to deny reimbursement to Claimant for his motel lodging and food expenses. The prior order's denial of reimbursement for motel lodging and food expenses were for a specified period of time, August 9, 2007, to September 17, 2007, and made no determination as to future medical benefits. The facts here are different, and the issues are different. Accordingly, the doctrines of res judicata, law of the case and collateral estoppel are not relevant and do not apply.

ORDER

It is therefore ordered that:

1. Respondents shall reimburse Claimant $1,360.00 for lodging, $376.79 in food expenses and $64.51 for his orthotic.

2. Respondents shall pay statutory interest at the rate of eight percent (8%) per annum on all amounts not paid when due.

3. Any and all issues not determined herein are reserved for future decision.

DATED: _January 26, 2010__

Margot W. Jones
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO

WORKERS' COMPENSATION NO. WC 4-774-224

ISSUES

The issues determined herein are permanent partial disability ("PPD") benefits and disfigurement benefits.

FINDINGS OF FACT

1. In 2003, claimant suffered a previous work injury to her neck. She was diagnosed with disc bulges at C4-5 through C6-7. She suffered continuing neck pain and left arm pain. Dr. Griffis provided continuing treatment for that injury and then Dr. Johnson provided continuing treatment.

2. On February 3, 2008, claimant began work for employer as a waitress. On September 29, 2008, claimant suffered an admitted work injury to her right shoulder when she reached to serve with her right arm and felt a pop and pain in the anterior aspect of her right shoulder and her upper arm.

3. Dr. Schwender provided conservative treatment.

4. An October 9, 2008, magnetic resonance image ("MRI") showed minimal spurring of the acromioclavicular ("AC") joint.

5. On January 27, 2009, Dr. Stockelman performed surgery for a subacromial decompression with acromion resection. Dr. Stockelman did not perform a clavicle resection.

6. Claimant underwent a course of physical therapy after surgery and improved. On March 4, 2009, the physical therapist noted that claimant was "doing great" with full active and passive range of motion of the right shoulder.

7. On March 4, 2009, Dr. Stockelman reexamined claimant, who reported that she was "ecstatic" because she had no pain and was able to do virtually anything. Dr. Stockelman also noted full range of motion of the shoulder.

8. On March 4, 2009, Dr. Schwender reexamined claimant and found full range of motion without pain. He determined that claimant was at maximum medical improvement ("MMI") with no permanent impairment.

9. On March 11, 2009, the insurer filed a final admission of liability ("FAL") denying liability for any PPD benefits. Claimant objected and requested a Division Independent Medical Examination ("DIME").

10. On March 21, 2009, claimant returned to her regular work for the employer. She has modified her job slightly by carrying trays with her right hand below her waist and serving with her left hand. She also now uses her left hand to scrub the walls.

11. On August 26, 2009, Dr. Struck performed the DIME. She agreed with the date of MMI. Claimant reported that she felt only pinch-like sensation if she engaged in flexion/abduction. Dr. Struck determined that claimant had 2% impairment of the upper extremity due to loss of flexion, 2% due to loss of abduction, and 2% for loss of internal rotation. Dr. Struck determined 6% impairment of the upper extremity due to loss of shoulder range of motion. Dr. Struck also determined 10% impairment for acromioplasty with distal clavicular resection. In her narrative report, Dr. Struck noted that Dr. Stockelman performed the decompression surgery with acromion resection and debridement. Dr. Struck combined the impairments to determine a total 15% impairment of the upper extremity, which she converted to 9% whole person.

12. On September 10, 2009, the insurer filed a FAL for PPD benefits based upon 15% of the right arm at the shoulder.

13. On December 16, 2009, Dr. Scott performed an IME for respondents. Claimant reported that she suffered pain in the anterior aspect of her right shoulder when she engaged in abduction. She denied any neck or trapezius pain from the work injury. Dr. Scott disagreed with Dr. Struck's determination of 10% for a distal clavicle resection. Dr. Scott noted that the Division of Workers' Compensation impairment "rating tips" suggested 10% impairment be used only for a distal clavicle resection, not for an acromion resection. Dr. Scott determined that claimant suffered only 6% impairment of the upper extremity due to the range of motion losses measured by the DIME. Dr. Scott obtained right shoulder range of motion measurements that were similar to those measured by Dr. Struck.

14. Claimant has done very well after her shoulder surgery. She decreased pain and increased function. She has some residual problems only with certain activities requiring her to reach across her body with her right arm elevated, e.g. putting her hair in a "high ponytail." She has altered her job performance slightly to avoid using her right arm in flexion/abduction to serve food.

15. Claimant has a functional impairment not expressed on the schedule of disabilities. Claimant's impairment is not limited to the right arm below the glenohumeral joint. She suffered the injury to the AC joint, proximal to the glenohumeral joint. She has functional limitations with range of motion of the entire right shoulder musculature, proximal to the right arm.

16. Clear and convincing evidence demonstrates that Dr. Struck erred by providing 10% impairment for a distal clavicle resection when claimant did not have such a surgical procedure. The parties did not put into record evidence the Division's "rating tips." Nevertheless, the record evidence was that the 10% rating is only to be provided for a clavicle resection, not for an acromion resection. At hearing, claimant conceded that Dr. Struck probably erred by providing that component of the rating. Consequently, claimant suffered 4% whole person impairment due to loss of right shoulder range of motion.

17. Claimant suffered a serious and permanent bodily disfigurement normally exposed to public view, described as three arthroscopic surgery scars on the front, side, and back of her right shoulder.

CONCLUSIONS OF LAW

1. Section 8-42-107, C.R.S., sets forth two different methods of compensating medical impairment. Subsection (2) provides a schedule of disabilities and Subsection (8) provides a DIME process for whole person ratings. The threshold issue is application of the schedule and this is a determination of fact based upon a preponderance of the evidence. The application of the schedule depends upon the "situs of the functional impairment" rather than just the situs of the original work injury. *Langton v. Rocky Mountain Health Care Corp.,* 937 P.2d 803 (Colo. App. 1996); *Strauch v. PSL Swedish Health Care System*, 917 P.2d 366 (Colo. App. 1996). The heightened burden of proof in Subsection (8) applies only if the threshold determination is made that the impairment is not limited to the schedule. Then, and only then, does either party face a clear and convincing evidence burden to overcome the rating of the DIME. *Webb v. Circuit City Stores, Inc.*, W.C. No. 4-467-005 (ICAO, August 16, 2002). As found, claimant has proven by a preponderance of the evidence that she suffered permanent functional impairment not expressed on the schedule.

2. The medical impairment determination of the DIME is binding unless overcome by clear and convincing evidence. Section 8-42-107(8), C.R.S.; *see Qual-Med, Inc. v. Industrial Claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998); *Cordova v. Industrial Claim Appeals Office,* 55 P.3d 186, 189-190 (Colo. App. 2002); *Sholund v. John Elway Dodge Arapahoe,* W.C. No. 4-522-173 (ICAO October 22, 2004); *Kreps v. United Airlines,* W.C. Nos. 4-565-545 and 4-618-577 (ICAO January 13, 2005). *Cudo v. Blue Mountain Energy Inc.*, W.C. No. 4-375-278 (Industrial Claim Appeals Office, October 29, 1999). A fact or proposition has been proved by "clear and convincing evidence" if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious or substantial doubt. *Metro Moving & Storage Co. v. Gussert*, 914 P.2d 411 (Colo. App. 1995). As found, clear and convincing evidence demonstrates that the medical impairment rating by the DIME is incorrect. As found, claimant suffered 4% whole person impairment.

3. Claimant suffered a serious and permanent bodily disfigurement normally exposed to public view. Pursuant to section 8-42-108, C.R.S., claimant is entitled to an award of up to $4,000. Considering the size, location, and general appearance, the Judge determines that claimant is entitled to $600 for disfigurement benefits.

ORDER

It is therefore ordered that:

1. The insurer shall pay to claimant PPD benefits based upon 4% whole person impairment. The insurer is entitled to credit for any previous payments of PPD benefits to claimant in this claim.

2. The insurer shall pay to claimant $600 in one lump sum for bodily disfigurement benefits.

3. The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

DATED: January 27, 2010

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-795-061

ISSUES

Whether Claimant has proven by a preponderance of the evidence that she sustained a compensable injury arising out of and in the course of her employment with Employer.

Whether Claimant is entitled to medical benefits and whether Dr. Hall should be considered an authorized treating physician on that basis that the right of selection passed to Claimant due to the Employer's designated physician refusing to provide further treatment.

At hearing, the parties stipulated that if found compensable, Claimant's Average Weekly Wage is $380.05. This stipulation was accepted by the Court.

FINDINGS OF FACT

Based upon the evidence presented, the ALJ finds as fact:

1. Claimant was employed as an associate in the deli department for Employer. Claimant began this employment in November 2008. Claimant was previously employed by Safeway for 6 ½ years before being laid off.

2. Claimant was not sure of and could not give an exact date for her injury. Claimant initially gave the date of injury as January 5, 2009 but was not sure of this date. Claimant testified that the injury occurred during a three-week period in December 2008 through January 2009. Claimant then identified the date of injury as December 20, 2008 because she worked on that day, because the incident had occurred a

couple of weeks prior to when she first sought medical care from the emergency room at Penrose Hospital and because that time-frame coincided with when freezer loads of food products were delivered to the store. The ALJ finds that the date of the injury is December 20, 2008.

3. On December 20, 2008 Claimant was moving boxes of frozen chicken with her department manager, Candida Smiley. Each box weighed approximately 35-40 pounds and Claimant and Ms. Smiley used a team lift procedure to move each box. As they lifted one of the boxes, Claimant heard and felt a "pop" in her right lower back and felt immediate pain in this area. The area of pain was located on Claimant's right side above the buttock area. The pain increased during the remainder of the day however, Claimant finished her shift.

4. Candida Smiley testified that she was lifting boxes of chicken with Claimant in the freezer when while they were lifting one of the boxes she heard something "pop" in Claimant. According to Ms. Smiley Claimant stated then she may have moved wrong. Ms. Smiley asked Claimant if she was "OK" and Claimant replied "yes", "I think so", "I don't know". Candida Smiley's testimony concerning the incident of December 20, 2008 while lifting boxes of chicken with Claimant is credible, persuasive and is found as fact.

5. The day after December 20, 2008 Claimant called her manager, Ms. Smiley, on Ms. Smiley's cell-phone and told Ms. Smiley that she was hurting too much to come to work. Ms. Smiley told Claimant to contact Bob Smith, the Assistant Store Manager, to report the injury.

6. Claimant reported the injury to Mr. Smith on December 21, 2008. Claimant advised him of the incident the day before and that she was still in pain. Mr. Smith told Claimant to rest, take it easy, to avoid lifting and to just perform work on the meat slicer. Over the course of the next couple of weeks, Mr. Smith brought Claimant some Aspercreme to use for her back pain and suggested she obtain a back brace. Mr. Smith did not refer Claimant for medical treatment or make a formal report of the incident. Claimant went home early from work on a few occasions due to pain

7. Claimant sought treatment for the injury for the first time at the Penrose Hospital emergency room on January 6, 2009. She sought treatment as this time because rest had not made the pain better. Claimant told the emergency room physician that she had strained her R lower back while lifting about three weeks ago and that the pain was worse over the past few days. At that time, Claimant denied a specific injury although she noted to the physician that she worked in a deli and was always bending, lifting and twisting. Claimant denied any prior history of back problems. The diagnosis provided by the emergency room physician was "back strain". Claimant was discharged from the emergency room with prescriptions for the medications Percocet and Flexeril and advised to use heat and rest with follow up in 3-4 days if the pain was not better.

8. After being treated in the emergency room, Claimant next sought treatment from Peak Vista Community Health Center through the Colorado Indigent Care

Program ("CICP"). Claimant was reluctant at this time to pursue a workers' compensation claim or further medical treatment with Employer as she was in her initial 90-day probationary employment period and was concerned about possibly losing her job.). Due to the nature of the program, it took several weeks to establish eligibility and obtain an appointment.

9. Claimant's initial appointment at Peak Vista took place on February 11, 2009, at which time she was evaluated by Carmen Aguirre, PA-C. The physical examination revealed findings consistent with a low back injury including limited range of motion of the right hip and muscle spasm in the right lumbo-sacral area.

10. At the time of her initial visit at Peak Vista Claimant gave the physicians' assistant a history that she had injured her back lifting furniture. Claimant gave this history to the physicians' assistant because she was concerned that if she indicated the injury was work related she would be refused case by Peak Vista. Physicians Assistant Aguirre testified, and it is found, that Peak Vista's policy is not treat to patients who have a work-related injury; and that if a patient comes in and states they have a work-related injury, the patient is advised to go through their workers' compensation and get their treatment elsewhere.

11. Claimant admitted that the history she gave to the physicians' assistant at Peak Vista was incorrect and that she was wrong in doing this.

12. Claimant received treatment Ms. Rosario received conservative treatment over the following two months through Peak Vista, including medication and physical therapy. Claimant was referred by Physicians' Assistant Aguirre for an MRI and in April 2009 was referred to an orthopedist for evaluation.

13. After receiving the results of the MRI and being referred to an orthopedist Claimant determined that her injury was more serious than she had originally hoped. Claimant then decided that she needed to pursue a claim for workers' compensation benefits with Employer because the injury was more serious that she had anticipated and because she could no longer afford treatment on her own.

14. On April 24, 2009 Claimant again reported her injury to Employer and that at time was referred to Emergicare for treatment. Claimant was initially evaluated at Emergicare on April 23, 2009 by Dr. Christopher Prior, D.O. who obtained a history that Claimant had hurt her back while lifting heavy boxes in a freezer. Dr. Prior diagnosed "Lower back pain – chronic with a myofascial strain". Dr. Prior further opined, and it is found, that the mechanism of injury was consistent with the clinical presentation.

15. On May 10, 2009, Dr. Prior referred Claimant to Dr. MIchael Sparr, because she was not responding to physical therapy. Claimant was initially evaluated by Dr. Sparr on May 28, 2009 and gave a history that she was working as a deli clerk, lifting a 50-pound box from the floor with the aid of her manager when she felt a sharp, stabbing pain in her right central back and buttock. Dr. Sparr diagnosed right sacroiliac sprain/strain injury with persistent sacroiliitis, and myofascial involvement of the right lumbo-sacral area and possible discogenic pain. Dr. Sparr recommended injection ther-

apy and changes to her physical therapy regimen. Dr. Sparr also referred Claimant to Dr. Ford for a right SI joint injection that Dr. Ford performed on June 15, 2009.

16. Claimant was evaluated by Dr. Prior for follow-up on May 26, 2009. Dr. Prior noted that Claimant was tender in the SI joint with no changes in her physical examination. Dr. Prior set Claimant for a return appointment in 3 weeks.

17. Respondents filed a Notice of Contest on or about June 12, 2009 and sent a letter to Claimant of that date advising her that her claim for workers' compensation benefits was being denied.

18. When Claimant reported for her June 16, 2009 appointment with Dr. Prior at Emergicare, she was refused treatment due to lack of authorization. When Claimant inquired as to why she was not able to receive treatment it was mentioned to her that her claim had been denied. On July 13, 2009 counsel for Claimant sent Respondents a letter advising them of Claimant's position that the designated physicians at Emergicare had refused Claimant further medical treatment on the basis that her claim had been denied. Respondents did not refer Ms. Rosario to another physician or authorize further treatment with Emergicare.

19. Claimant was evaluated by Dr. Timothy Hall, M.D. at the request of her counsel. Dr. Hall initially evaluated Claimant on August 28, 2009. Dr. Hall agreed with the diagnoses provided by Dr. Sparr, performed a trigger point injection, prescribed medication and recommended that Claimant receive further treatment. When questioned at his deposition regarding causation of the injury Dr. Hall testified that without more information than he had been provided he could not give a definitive answer about causation.

20. Claimant has proven by a preponderance of the evidence that she sustained a compensable injury to her low back on December 20, 2008 arising out of and in the course of her employment with Employer. The ALJ finds Claimant's testimony to be credible and persuasive. Claimant's testimony regarding the incident on December 20, 2008 lifting boxes of chicken products is corroborated by the credible testimony of her supervisor, Candida Smiley. That incident caused Claimant to seek medical treatment and to miss time from work because of the pain in her low back.

21. Employer failed to designate a treatment physician at the time Claimant reported her injury to the Assistant Store Manager, Mr. Smith on December 21, 2008. At that time, the right of selection of a treating physician passed to Claimant. Claimant initially obtained emergency type treatment from Penrose Hospital and then selected Peak Vista Community Health Center for further treatment. The ALJ finds that Peak Vista Community Health Center, PA-C Aguirre, became Claimant's authorized treating physician.

CONCLUSIONS OF LAW

22. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

23. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

24. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

25. In order to recover benefits a claimant must prove that she sustained a compensable injury. A compensable injury is one which arises out of and in the course of employment. Section 8-41-301(1)(b), C.R.S. The "arising out of" test is one of causation. It requires that the injury have its origins in an employee's work-related functions. There is no presumption that an injury which occurs in the course of a worker's employment arises out of the employment. *Finn v. Indus. Comm'n,* 165 Colo. 106, 437 P.2d 542 (1968). It is the claimant's burden to prove by a preponderance of the evidence that there is a direct causal relationship between the employment and the injuries. *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989).

26. Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any benefits are awarded. Section 8-41-301(1)(c), C.R.S.; *Faulkner v. Indus. Claim Appeals Office*, 12 P3d 844, 846 (Colo. App. 2000).

27. The evidence must establish the causal connection with reasonable probability, not medical certainty. *Ringsby Truck Lines, Inc. v. Industrial Commission, 491 P.2d 106 (Colo. App. 1971)*. Reasonable probability exists if the proposition is supported by substantial evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding. *F.R. Orr Construction v. Rinta, 717 P.2d 965 (Colo. App. 1985)*. An award of benefits may not be based upon or denied upon speculation or conjecture. *Deines Bros. v. Indus. Comm'n,* 125 Colo. 258, 242 P.2d 600 (1952); *Indus. Comm'n v. Havens,* 136 Colo. 111, 134 P.2d 698 (1957).

28. In order to prove entitlement to benefits a Claimant must prove an event occurred at work which arose out of and occurred in the course of performance of employment which either required healthcare treatment and/or disabled the Claimant from performing her regular job duties. No benefits flow to the victim of an industrial "accident" unless the "accident" results in a compensable "injury". A compensable injury is one which requires medical treatment or causes disability. See *City of Boulder v.* Payne, 162 Colo. 345, 416, P.2d 194 (Colo. 1967). It is Claimant's burden of proof to establish she sustained a compensable injury. *Id.*

29. It is up to the ALJ to determine if Claimant met her burden of proof and established an injury occurred which required medical treatment. See *F.R. Orr Const. v. Rinta,* supra.

30. If upon notice of the injury the employer fails forthwith to designate an ATP, the right of selection passes to the claimant. *Rogers v. Industrial Claim Appeals Office,* 746 P.2d 565 (Colo. App. 1987). The employer's obligation to appoint an ATP arises when it has some knowledge of the accompanying facts connecting an injury to the employment such that a reasonably conscientious manager would recognize the case might result in a claim for compensation. *Bunch v. Industrial Claim Appeals Office,* 148 P.3d 381 (Colo. App. 2006). Once an authorized treating physician has been selected the claimant may not ordinarily change physicians or employ additional physicians without obtaining permission from the insurer or an ALJ. If the claimant does so, the respondents are not liable for the unauthorized treatment. *Yeck v. Industrial Claim Appeals Office,* 996 P.2d 228 (Colo. App. 1999).

31. Section 8-43-404(5)(a) contemplates that respondents will designate a physician who is willing to provide treatment without regard to non-medical issues such as the prospects for payment in the event the claim is ultimately denied. *Lutz v. Industrial Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000); *Ruybal v. University of Colorado Health Sciences Center,* 768 P.2d 1259 (Colo. App. 1988). However, the fact that an ATP stops providing treatment based on the *medical determination* that further treatment is not warranted does not automatically authorize the claimant to change physicians. Rather, the claimant must seek applicable statutory remedies such as submitting a request for a change of physician or seeking a DIME. *See Bilyeu v. Babcock & Wilcox Inc.,* W.C. No. 4-349-701 (I.C.A.O. July 24, 2001), *aff'd., Bilyeu v. Industrial Claim Appeals Office,* (Colo. App. No. 01CA1505, April 11, 2002) (not selected for publication). Whether the ATP has refused to provide treatment for non-medical reasons is a question of fact for the ALJ. *Ruybal v. University of Colorado Health Sciences Center, supra.*

32. Respondents present two arguments in support of their request that compensability should be denied. First, Respondent's argue there is a lack of credible evidence that an incident occurred on December 20, 2008. The ALJ disagrees. As found, Claimant's testimony that she heard and felt a "pop" in the right side of her low back while lifting a box of chicken with her manager that caused pain and the inability to work

the next day is credible. Also as found, Claimant's testimony concerning the incident of December 20, 2008 is corroborated by the credible testimony of her manager, Ms. Smiley. Ms. Rosario concedes that she gave an inaccurate history to PA-C Aguirre at Peak Vista. Claimant credibly explained why she gave this inaccurate information and that explanation is supported and corroborated by the testimony of PA-C Aguirre. The ALJ finds that the fact that Claimant gave an inaccurate history to PA-C Aguirre is not sufficient to undermine the Claimant's credibility regarding the incident and injury of December 20, 2008 considering the corroborating testimony of Ms. Smiley and PA-C Aguirre.

33. Respondents' second argument is that the incident of December 20, 2008 did not cause an "injury", as that term is defined for purposes of the workers' compensation act, and accordingly, compensability should be denied. Again, the ALJ disagrees. Claimant sought treatment for her low back initially on January 6, 2009 due an incident of lifting. There is no persuasive evidence in the record that Claimant sought treatment on this date for a pre-existing low back problem or for an incident of lifting other than the incident at work in the freezer lifting a box of chicken products. As found, the incident of December 20, 2008 caused the need for medical treatment. Additionally, Claimant called her manager the next day to advise that she was unable to come to work due to the pain in her low back. Thus, and as found, the incident of December 20, 2008 caused a disabiliy in that Claimant was unable to work the next day due to the pain and modified her work duties, at the direction of her Assistant Store Manager, over at least the next couple of weeks. The incident of December 20, 2008 caused Claimant to sustain an injury, i.e. caused the need for medical care and disabled Claimant from being able to perform her regular work duties.

34. The ALJ concludes that contrary to Claimant's argument, the right of selection of the authorized treating physician passed to Claimant at the time she reported her injury to the Assistant Store Manager in December 2008 and was not referred to a physician by Employer. Claimant reported to Mr. Smith that she had an incident on the day previous that had caused her back pain and that she was unable to work. A reasonably conscientious manager would have recognized that this report might result in a claim for compensation and this triggered Employer' As found, Claimant thereafter selected Peak Vista Community Health Center and PA-C Aguirre as her treating physician. Claimant, having selected Peak Vista, is not entitled to select a different treating physician even though the physicians later designated by Respondents, Emergicare, refused further treatment on the basis that Claimant's claim had been denied. The ALJ concludes that Claimant was therefore not entitled to select Dr. Hall, to whom she had be referred by her attorney, at her authorized treating physician. The authorized treating physicians are Peak Vista Community Health Center and Emergicare.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation and benefits for an injury on December 20, 2008 is compensable and is granted.

2. As stipulated by the parties, Claimant's Average Weekly Wage is $380.05.
3. Insurer shall pay, according to the Official Medical Fee Schedule of the Division of Workers' Compensation, for reasonable and necessary medical treatment that is related to the compensable injury of December 20, 2008 from the authorized treating physicians Peak Vista Community Health Center and Emergicare and their referrals.
4. Claimant's request that Dr. Timothy Hall, M.D. be considered an authorized treating physician is denied.
The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: January 27, 2010

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-795-061

ISSUES

Whether Claimant has proven by a preponderance of the evidence that she sustained a compensable injury arising out of and in the course of her employment with Employer.

Whether Claimant is entitled to medical benefits and whether Dr. Hall should be considered an authorized treating physician on that basis that the right of selection passed to Claimant due to the Employer's designated physician refusing to provide further treatment.

At hearing, the parties stipulated that if found compensable, Claimant's Average Weekly Wage is $380.05. This stipulation was accepted by the Court.

FINDINGS OF FACT

Based upon the evidence presented, the ALJ finds as fact:

1. Claimant was employed as an associate in the deli department for Employer. Claimant began this employment in November 2008. Claimant was previously employed by Safeway for 6 ½ years before being laid off.

2. Claimant was not sure of and could not give an exact date for her injury. Claimant initially gave the date of injury as January 5, 2009 but was not sure of this date. Claimant testified that the injury occurred during a three-week period in December 2008 through January 2009. Claimant then identified the date of injury as December 20, 2008 because she worked on that day, because the incident had occurred a couple of weeks prior to when she first sought medical care from the emergency room at Penrose Hospital and because that time-frame coincided with when freezer loads of food products were delivered to the store. The ALJ finds that the date of the injury is December 20, 2008.

3. On December 20, 2008 Claimant was moving boxes of frozen chicken with her department manager, Candida Smiley. Each box weighed approximately 35-40 pounds and Claimant and Ms. Smiley used a team lift procedure to move each box. As they lifted one of the boxes, Claimant heard and felt a "pop" in her right lower back and felt immediate pain in this area. The area of pain was located on Claimant's right side above the buttock area. The pain increased during the remainder of the day however, Claimant finished her shift.

4. Candida Smiley testified that she was lifting boxes of chicken with Claimant in the freezer when while they were lifting one of the boxes she heard something "pop" in Claimant. According to Ms. Smiley Claimant stated then she may have moved wrong. Ms. Smiley asked Claimant if she was "OK" and Claimant replied "yes", "I think so", "I don't know". Candida Smiley's testimony concerning the incident of December 20, 2008 while lifting boxes of chicken with Claimant is credible, persuasive and is found as fact.

5. The day after December 20, 2008 Claimant called her manager, Ms. Smiley, on Ms. Smiley's cell-phone and told Ms. Smiley that she was hurting too much to come to work. Ms. Smiley told Claimant to contact Bob Smith, the Assistant Store Manager, to report the injury.

6. Claimant reported the injury to Mr. Smith on December 21, 2008. Claimant advised him of the incident the day before and that she was still in pain. Mr. Smith told Claimant to rest, take it easy, to avoid lifting and to just perform work on the meat slicer. Over the course of the next couple of weeks, Mr. Smith brought Claimant some Aspercreme to use for her back pain and suggested she obtain a back brace. Mr. Smith did not refer Claimant for medical treatment or make a formal report of the incident. Claimant went home early from work on a few occasions due to pain

7. Claimant sought treatment for the injury for the first time at the Penrose Hospital emergency room on January 6, 2009. She sought treatment as this time because rest had not made the pain better. Claimant told the emergency room physician that she had strained her R lower back while lifting about three weeks ago and that the

pain was worse over the past few days. At that time, Claimant denied a specific injury although she noted to the physician that she worked in a deli and was always bending, lifting and twisting. Claimant denied any prior history of back problems. The diagnosis provided by the emergency room physician was "back strain". Claimant was discharged from the emergency room with prescriptions for the medications Percocet and Flexeril and advised to use heat and rest with follow up in 3-4 days if the pain was not better.

8. After being treated in the emergency room, Claimant next sought treatment from Peak Vista Community Health Center through the Colorado Indigent Care Program ("CICP"). Claimant was reluctant at this time to pursue a workers' compensation claim or further medical treatment with Employer as she was in her initial 90-day probationary employment period and was concerned about possibly losing her job.). Due to the nature of the program, it took several weeks to establish eligibility and obtain an appointment.

10. Claimant's initial appointment at Peak Vista took place on February 11, 2009, at which time she was evaluated by Carmen Aguirre, PA-C. The physical examination revealed findings consistent with a low back injury including limited range of motion of the right hip and muscle spasm in the right lumbo-sacral area.

10. At the time of her initial visit at Peak Vista Claimant gave the physicians' assistant a history that she had injured her back lifting furniture. Claimant gave this history to the physicians' assistant because she was concerned that if she indicated the injury was work related she would be refused case by Peak Vista. Physicians Assistant Aguirre testified, and it is found, that Peak Vista's policy is not treat to patients who have a work-related injury; and that if a patient comes in and states they have a work-related injury, the patient is advised to go through their workers' compensation and get their treatment elsewhere.

11. Claimant admitted that the history she gave to the physicians' assistant at Peak Vista was incorrect and that she was wrong in doing this.

12. Claimant received treatment Ms. Rosario received conservative treatment over the following two months through Peak Vista, including medication and physical therapy. Claimant was referred by Physicians' Assistant Aguirre for an MRI and in April 2009 was referred to an orthopedist for evaluation.

13. After receiving the results of the MRI and being referred to an orthopedist Claimant determined that her injury was more serious than she had originally hoped. Claimant then decided that she needed to pursue a claim for workers' compensation benefits with Employer because the injury was more serious that she had anticipated and because she could no longer afford treatment on her own.

14. On April 24, 2009 Claimant again reported her injury to Employer and that at time was referred to Emergicare for treatment. Claimant was initially evaluated at Emergicare on April 23, 2009 by Dr. Christopher Prior, D.O. who obtained a history that Claimant had hurt her back while lifting heavy boxes in a freezer. Dr. Prior diagnosed

"Lower back pain – chronic with a myofascial strain". Dr. Prior further opined, and it is found, that the mechanism of injury was consistent with the clinical presentation.

15. On May 10, 2009, Dr. Prior referred Claimant to Dr. MIchael Sparr, because she was not responding to physical therapy. Claimant was initially evaluated by Dr. Sparr on May 28, 2009 and gave a history that she was working as a deli clerk, lifting a 50-pound box from the floor with the aid of her manager when she felt a sharp, stabbing pain in her right central back and buttock. Dr. Sparr diagnosed right sacroiliac sprain/strain injury with persistent sacroiliitis, and myofascial involvement of the right lumbo-sacral area and possible discogenic pain. Dr. Sparr recommended injection therapy and changes to her physical therapy regimen. Dr. Sparr also referred Claimant to Dr. Ford for a right SI joint injection that Dr. Ford performed on June 15, 2009.

16. Claimant was evaluated by Dr. Prior for follow-up on May 26, 2009. Dr. Prior noted that Claimant was tender in the SI joint with no changes in her physical examination. Dr. Prior set Claimant for a return appointment in 3 weeks.

17. Respondents filed a Notice of Contest on or about June 12, 2009 and sent a letter to Claimant of that date advising her that her claim for workers' compensation benefits was being denied.

18. When Claimant reported for her June 16, 2009 appointment with Dr. Prior at Emergicare, she was refused treatment due to lack of authorization. When Claimant inquired as to why she was not able to receive treatment it was mentioned to her that her claim had been denied. On July 13, 2009 counsel for Claimant sent Respondents a letter advising them of Claimant's position that the designated physicians at Emergicare had refused Claimant further medical treatment on the basis that her claim had been denied. Respondents did not refer Ms. Rosario to another physician or authorize further treatment with Emergicare.

19. Claimant was evaluated by Dr. Timothy Hall, M.D. at the request of her counsel. Dr. Hall initially evaluated Claimant on August 28, 2009. Dr. Hall agreed with the diagnoses provided by Dr. Sparr, performed a trigger point injection, prescribed medication and recommended that Claimant receive further treatment. When questioned at his deposition regarding causation of the injury Dr. Hall testified that without more information than he had been provided he could not give a definitive answer about causation.

20. Claimant has proven by a preponderance of the evidence that she sustained a compensable injury to her low back on December 20, 2008 arising out of and in the course of her employment with Employer. The ALJ finds Claimant's testimony to be credible and persuasive. Claimant's testimony regarding the incident on December 20, 2008 lifting boxes of chicken products is corroborated by the credible testimony of her supervisor, Candida Smiley. That incident caused Claimant to seek medical treatment and to miss time from work because of the pain in her low back.

21. Employer failed to designate a treatment physician at the time Claimant reported her injury to the Assistant Store Manager, Mr. Smith on December 21, 2008. At that time, the right of selection of a treating physician passed to Claimant. Claimant initially obtained emergency type treatment from Penrose Hospital and then selected Peak Vista Community Health Center for further treatment. The ALJ finds that Peak Vista Community Health Center, PA-C Aguirre, became Claimant's authorized treating physician.

CONCLUSIONS OF LAW

22. The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2008), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, *supra*. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*. A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*.

23. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005).

24. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

25. In order to recover benefits a claimant must prove that she sustained a compensable injury. A compensable injury is one which arises out of and in the course of employment. Section 8-41-301(1)(b), C.R.S. The "arising out of" test is one of causation. It requires that the injury have its origins in an employee's work-related functions. There is no presumption that an injury which occurs in the course of a worker's employment arises out of the employment. *Finn v. Indus. Comm'n,* 165 Colo. 106, 437 P.2d 542 (1968). It is the claimant's burden to prove by a preponderance of the evidence that there is a direct causal relationship between the employment and the injuries. *Ramsdell v. Horn,* 781 P.2d 150 (Colo. App. 1989).

26. Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any benefits are awarded.

Section 8-41-301(1)(c), C.R.S.; *Faulkner v. Indus. Claim Appeals Office*, 12 P3d 844, 846 (Colo. App. 2000).

27. The evidence must establish the causal connection with reasonable probability, not medical certainty. *Ringsby Truck Lines, Inc. v. Industrial Commission, 491 P.2d 106 (Colo. App. 1971)*. Reasonable probability exists if the proposition is supported by substantial evidence which would warrant a reasonable belief in the existence of facts supporting a particular finding. *F.R. Orr Construction v. Rinta, 717 P.2d 965 (Colo. App. 1985)*. An award of benefits may not be based upon or denied upon speculation or conjecture. *Deines Bros. v. Indus. Comm'n,* 125 Colo. 258, 242 P.2d 600 (1952); *Indus. Comm'n v. Havens,* 136 Colo. 111, 134 P.2d 698 (1957).

28. In order to prove entitlement to benefits a Claimant must prove an event occurred at work which arose out of and occurred in the course of performance of employment which either required healthcare treatment and/or disabled the Claimant from performing her regular job duties. No benefits flow to the victim of an industrial "accident" unless the "accident" results in a compensable "injury". A compensable injury is one which requires medical treatment or causes disability. See *City of Boulder v.* Payne, 162 Colo. 345, 416, P.2d 194 (Colo. 1967). It is Claimant's burden of proof to establish she sustained a compensable injury. *Id.*

29. It is up to the ALJ to determine if Claimant met her burden of proof and established an injury occurred which required medical treatment. See *F.R. Orr Const. v. Rinta,* supra.

30. If upon notice of the injury the employer fails forthwith to designate an ATP, the right of selection passes to the claimant. *Rogers v. Industrial Claim Appeals Office,* 746 P.2d 565 (Colo. App. 1987). The employer's obligation to appoint an ATP arises when it has some knowledge of the accompanying facts connecting an injury to the employment such that a reasonably conscientious manager would recognize the case might result in a claim for compensation. *Bunch v. Industrial Claim Appeals Office,* 148 P.3d 381 (Colo. App. 2006). Once an authorized treating physician has been selected the claimant may not ordinarily change physicians or employ additional physicians without obtaining permission from the insurer or an ALJ. If the claimant does so, the respondents are not liable for the unauthorized treatment. *Yeck v. Industrial Claim Appeals Office,* 996 P.2d 228 (Colo. App. 1999).

31. Section 8-43-404(5)(a) contemplates that respondents will designate a physician who is willing to provide treatment without regard to non-medical issues such as the prospects for payment in the event the claim is ultimately denied. *Lutz v. Industrial Claim Appeals Office,* 24 P.3d 29 (Colo. App. 2000); *Ruybal v. University of Colorado Health Sciences Center,* 768 P.2d 1259 (Colo. App. 1988). However, the fact that an ATP stops providing treatment based on the *medical determination* that further treatment is not warranted does not automatically authorize the claimant to change physicians. Rather, the claimant must seek applicable statutory remedies such as submit-

ting a request for a change of physician or seeking a DIME. *See Bilyeu v. Babcock & Wilcox Inc.,* W.C. No. 4-349-701 (I.C.A.O. July 24, 2001), *aff'd., Bilyeu v. Industrial Claim Appeals Office,* (Colo. App. No. 01CA1505, April 11, 2002) (not selected for publication). Whether the ATP has refused to provide treatment for non-medical reasons is a question of fact for the ALJ. *Ruybal v. University of Colorado Health Sciences Center, supra.*

32. Respondents present two arguments in support of their request that compensability should be denied. First, Respondent's argue there is a lack of credible evidence that an incident occurred on December 20, 2008. The ALJ disagrees. As found, Claimant's testimony that she heard and felt a "pop" in the right side of her low back while lifting a box of chicken with her manager that caused pain and the inability to work the next day is credible. Also as found, Claimant's testimony concerning the incident of December 20, 2008 is corroborated by the credible testimony of her manager, Ms. Smiley. Ms. Rosario concedes that she gave an inaccurate history to PA-C Aguirre at Peak Vista. Claimant credibly explained why she gave this inaccurate information and that explanation is supported and corroborated by the testimony of PA-C Aguirre. The ALJ finds that the fact that Claimant gave an inaccurate history to PA-C Aguirre is not sufficient to undermine the Claimant's credibility regarding the incident and injury of December 20, 2008 considering the corroborating testimony of Ms. Smiley and PA-C Aguirre.

33. Respondents' second argument is that the incident of December 20, 2008 did not cause an "injury", as that term is defined for purposes of the workers' compensation act, and accordingly, compensability should be denied. Again, the ALJ disagrees. Claimant sought treatment for her low back initially on January 6, 2009 due an incident of lifting. There is no persuasive evidence in the record that Claimant sought treatment on this date for a pre-existing low back problem or for an incident of lifting other than the incident at work in the freezer lifting a box of chicken products. As found, the incident of December 20, 2008 caused the need for medical treatment. Additionally, Claimant called her manager the next day to advise that she was unable to come to work due to the pain in her low back. Thus, and as found, the incident of December 20, 2008 caused a disabiliy in that Claimant was unable to work the next day due to the pain and modified her work duties, at the direction of her Assistant Store Manager, over at least the next couple of weeks. The incident of December 20, 2008 caused Claimant to sustain an injury, i.e. caused the need for medical care and disabled Claimant from being able to perform her regular work duties.

34. The ALJ concludes that contrary to Claimant's argument, the right of selection of the authorized treating physician passed to Claimant at the time she reported her injury to the Assistant Store Manager in December 2008 and was not referred to a physician by Employer. Claimant reported to Mr. Smith that she had an incident on the day previous that had caused her back pain and that she was unable to work. A reasonably conscientious manager would have recognized that this report might result in a claim for compensation and this triggered Employer' As found, Claimant thereafter selected Peak Vista Community Health Center and PA-C Aguirre as her treating physician.

Claimant, having selected Peak Vista, is not entitled to select a different treating physician even though the physicians later designated by Respondents, Emergicare, refused further treatment on the basis that Claimant's claim had been denied. The ALJ concludes that Claimant was therefore not entitled to select Dr. Hall, to whom she had be referred by her attorney, at her authorized treating physician. The authorized treating physicians are Peak Vista Community Health Center and Emergicare.

ORDER

It is therefore ordered that:

1. Claimant's claim for compensation and benefits for an injury on December 20, 2008 is compensable and is granted.

5. As stipulated by the parties, Claimant's Average Weekly Wage is $380.05.

6. Insurer shall pay, according to the Official Medical Fee Schedule of the Division of Workers' Compensation, for reasonable and necessary medical treatment that is related to the compensable injury of December 20, 2008 from the authorized treating physicians Peak Vista Community Health Center and Emergicare and their referrals.

7. Claimant's request that Dr. Timothy Hall, M.D. be considered an authorized treating physician is denied.

The insurer shall pay interest to claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

All matters not determined herein are reserved for future determination.

DATED: January 27, 2010

Ted A. Krumreich
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-724-017

ISSUES

1. Penalties for violation of Section 8-43-203, C.R.S. (failure to admit/deny claim within 20 days);

2. Penalties for violation of W.C.R.P. 5-2(B)(3) (failure to file Employer's first report of injury within 10 days);

3. TTD from 6/28/08 through 11/20/08;

4. Average weekly wage;

5. Penalties for violation of Section 8-42-102(2)(d), C.R.S. (calculation of AWW);

6. Penalties for violation of Section 8-43-401, C.R.S. and W.C.R.P. 5-5(B);

7. Interest;

8. Attorney's fees against Claimant under Section 8-43-211(2)(d), C.R.S. for Claimant's endorsement of alleged violations of Section 8-43-401, C.R.S. and W.C.R.P. 5-5(B) that were not ripe; and

9. Penalty against Claimant for violation of Section 8-43-304(1) for failing to plead penalties under Section 8-43-401, C.R.S. with specificity.

FINDINGS OF FACT

1. Claimant sustained an admitted work related injury on January 20, 2007. Claimant timely reported the injury to her supervisor on January 20, 2007. Claimant's supervisor accompanied her to Arbor Occupational Medicine on February 1, 2007. Claimant was placed on modified duty and returned to work.

2. Employer completed a first report of injury on February 4, 2007 with an attached supplemental statement setting forth that Claimant was currently working modified or transitional duty. There is no credible and persuasive evidence showing when this report was filed, if ever, with the Division or Insurer.

3. Insurer completed a general admission of liability dated May 24, 2007 admitting to medical benefits and temporary total disability (TTD) benefits beginning May 7, 2007. The admission admitted to an average weekly wage (AWW) of $775.39. On July 9, 2007, the Division of Worker's Compensation sent a letter to Claimant informing her that Employer had not filed a position as to admission or denial of the claim. On July 13, 2007, Insurer faxed a copy of the May 24, 2007 admission of liability to the Division of Worker's Compensation. The Division of Workers' Compensation first received the May 24, 2007 admission of liability on July 13, 2007.

4. Claimant testified that she first received the May 24, 2007 admission of liability on June 26, 2007. Because the May 24, 2007 admission of liability did not admit for lost wages from January 20, 2007 to May 7, 2007, Claimant filed a worker's claim for compensation on July 18, 2007 with an attached application for hearing listing TTD from 1/20/07 to 5/7/07, mileage, and penalty for Respondents' failure to timely file an admission or denial of liability pursuant to Section 8-43-203, C.R.S.

5. Employer's first report of injury is dated February 4, 2007. There is no credible and persuasive evidence showing when Insurer received Employer's February 4, 2007 first report of injury. Claimant testified that she called Insurer to report her injury and wage loss but did not give a date when this occurred. The evidence shows that Insurer was on notice of Claimant's injury and wage loss by May 24, 2007 when they

completed an admission of liability. Insurer filed the admission of liability with the Division of Workers' Compensation on July 13, 2007. The admission of liability was due on or before June 13, 2007 and was filed 30 days late.

6. Claimant's July 18, 2007 application for hearing properly endorsed penalty for Respondents' failure to timely file an admission or denial of liability pursuant to Section 8-43-203, C.R.S. Claimant hired an attorney to represent her and the hearing scheduled by this application was continued upon request of Respondents. Claimant filed applications for hearing dated November 17, 2008 and November 24, 2008 listing penalties per Sections 8-43-203(2) and 8-43-305, C.R.S., Rule 5(B)(5), Colorado Division of Workers' Compensation Rules of Procedure, and Section 8-43-301(1), C.R.S. Administrative Law Judge DeMarino set forth in his May 18, 2009 Pre-Hearing Conference Order that Claimant withdrew her February 6, 2009 application for hearing and was refilling her May 7, 2009 application for hearing on May 15, 2009. He further vacated the June 2, 2009 hearing. The May 7, 2009 application for hearing listed a number of issues including penalties for violation of WCRP 5-2(B)(3) and WCRP 5-5(B).

7. Insurer sent Claimant a check in the amount of $4,240.14 on July 21, 2008 indicating it was for "06/26/08 thru 11/02/08". Insurer sent Claimant a check in the amount of $559.84 on October 30, 2008 indicating it was for "06/27/08 thru 10/30/08". Insurer sent Claimant a check in the amount of $1,550.76 on October 20, 2008 indicating it was for "10/31/08 thru 11/20/08". It is unclear what benefits were paid by these checks.

8. Respondents filed a final admission on July 17, 2008 admitting to TTD from May 7, 2007 through June 25, 2008 and PPD from June 26, 2008 through November 3, 2008 for a 9% scheduled impairment. Respondents filed an admission of liability on October 28, 2008 admitting to TTD on May 7, 2007 and stated under remarks: "PPD, if any, to be determined at a late date. Dime found worker not to be MMI. Per Dr. Annu Ramaswamy, M.D. PPD is converted to TTD." Respondents filed an admission of liability dated December 8, 2008 admitting to TTD on May 7, 2007. This admission failed to indicate what time periods TTD was admitted and did not mention admission of TPD from January 20, 2007 to May 7, 2007. However, Insurer paid TPD from January 20, 2007 to May 7, 2007 (Claimant's Exhibit 3 and 13).

9. Claimant is seeking TTD from June 28, 2008 through November 20, 2008. Respondents admitted to TTD from June 28, 2008 through November 20, 2008 and paid part of the TTD due and owing for that time period. (See October 28, 2008 admission of liability converting the PPD to TTD). Additionally, Insurer sent Claimant two checks on September 9, 2009 in the amount of $2,645.99 for "06/27/08 THRU 11/03/08 TT UNDERPAYMENT" and $1,035.12 for TT Underpayment.

10. Claimant's 2007 W-2 shows she earned $8,286.64. Claimant's date of injury is January 20, 2007 and her last day of work was March 31, 2007. Claimant's testimony that her last day of work was March 31, 2007 is credible and persuasive and supported by Respondent's admission of liability dated September 11, 2009 admitting to TPD through March 31, 2007 and TTD on 4/1/07 (Claimant's Exhibit 13). Claimant's

wages from Employer for pay period ending January 20, 2007 (pay period January 14, 2007 through January 20, 2007) through March 31, 2007 was $5,452.45. During the first 14 days in January 2007, prior to the admitted injury, (pay periods December 31, 2006 through January 6, 2007 and January 7, 2007 through January 13, 2007) Claimant earned $2,834.19. Therefore, Claimant's average weekly wage is $1,417.09. The maximum TTD benefit rate at the time of Claimant's injury is $719.94.

11. Claimant's May 7, 2009 Amended Application for Hearing specifically states under 4. "Penalties Violation of 8-43-401 for failure to pay benefits from 6-26-08 thru 11-15-08." Claimant pled the penalty issue with sufficient specificity to put Respondents on notice of the issue. Additionally, Respondent and Claimant attended a pre-hearing conference on July 29, 2009 with Pre-hearing Judge Thomas O. McBride wherein the issues set on Claimant's application for hearing were discussed. Judge McBride set forth in his Pre-hearing Conference Order dated July 29, 2009, "The issues for consideration were respondents' and claimant's request to clarify hearing issues and consideration of issues endorsed by claimant in document entitled Amended Application for Hearing and claimant's Motion to Compel." After reviewing Claimant's May 7, 2009 Amended Application for Hearing, Judge McBride ordered that the issues set for hearing included Claimant's request for penalties against Respondents for alleged violation of Section 8-43-401, C.R.S. Respondents had more than sufficient notice and specific grounds for Claimant's request for penalties under Section 8-43-401, C.R.S.

12. Pre-hearing Judge Thomas O. McBride's July 28, 2009 Order specifically discussed the issues listed in Claimant's May 7, 2009 and July 29, 2009 Amended Applications for Hearing. Judge McBride's Order stated that Claimant's issues 2,5,8,9,10,11,14, and 16 were withdrawn without prejudice. Judge McBride further listed the issues that remained viable for the September 10, 2009 hearing and they are issues 1 through 7 stated above in this Order under Issues. However, Judge McBride inadvertently and mistakenly failed to mention Claimant's issue number 6 as stated in her July 28, 2009 Amended Application for Hearing. Although Claimant argued this issue in her position statement, the undersigned Judge failed to indicated that issue for hearing when she called the matter for hearing on September 10, 2009 because it was inadvertently omitted by Judge McBride. Therefore, this issue shall be set for hearing before the undersigned Judge along with two other issues that are more fully explained below.

CONCLUSIONS OF LAW

PENALTY FOR VIOLATION OF SECTION 8-43-203, C.R.S.

Section 8-43-203, C.R.S. (2001) provides that the insurer shall notify in writing the division and injured employee within twenty days after notice or knowledge of an injury that disables the employee for more than three shifts or calendar days whether liability is admitted or contested. Knowledge on the part of the employer is not knowledge on the part of the insurer.

Insurer completed a general admission of liability dated May 24, 2007 admitting to medical benefits and temporary total disability (TTD) benefits beginning May 7, 2007. The Insurer was aware that at least as of May 24, 2007, Claimant had been missing work beginning May 7, 2007. Although Claimant's last day of work was actually March 31, 2007, there is no credible and persuasive evidence proving that Insurer had actual knowledge that Claimant had missed three or more shifts or calendar days from work prior to May 24, 2007. Claimant testified that she contacted Insurer to report her injury and lost time but did not give a date. Employer's first report of injury is dated February 4, 2007 but there is no credible and persuasive evidence proving when Insurer received that report.

On July 9, 2007, the Division of Worker's Compensation sent a letter to Claimant informing her that Employer had not filed a position as to admission or denial of the claim. On July 13, 2007, Insurer faxed a copy of the May 24, 2007 admission of liability to the Division of Worker's Compensation. The Division of Workers' Compensation first received the May 24, 2007 admission of liability on July 13, 2007. The evidence shows that Insurer was on notice of Claimant's injury and wage loss by May 24, 2007 when they completed an admission of liability. Insurer filed the admission of liability with the Division of Workers' Compensation on July 13, 2007. The admission of liability was due on or before June 13, 2007 and was filed 30 days late. Therefore, Insurer shall pay a penalty equal to one day's compensation for 30 days or $102.84 per day for 30 days, which equals $3,085.44. Fifty percent (50%) or $1,542.72 is payable to Claimant and Fifty percent (50%) or $1,542.72 is payable to the Subsequent Injury Fund.

PENALTY FOR VIOLATION OF W.C.R.P. 5-2 (B)(3)

Claimant is requesting penalties against Employer for violation of W.C.R.P. 5-2 (B)(3), which provides as follows:

> W.C.R.P. 5-2 (B) A First Report of Injury shall be filed with the Division in a timely manner whenever any of the following apply. The insurer or third-party administrator may file the First Report of Injury on behalf of the employer.
>
> (1) In the event of an injury that results in a fatality, or an accident in which three or more employees are injured, the Division shall be notified immediately.
>
> (2) Within ten days after notice or knowledge by an employer that an employee has contracted an occupational disease listed below, or the occurrence of a permanently physically impairing injury, or that an injury or occupational disease has resulted in lost time from work for the injured employee in excess of three shifts or calendar days. An occupational disease that falls into any of the following categories requires the filing of a First Report of Injury:shifts or calendar days. An occupational disease that

falls into any of the following categories requires the filing of a First Report of Injury:

(a) Chronic respiratory disease;
(b) Cancer;
(c) Pneumoconiosis, including but not limited to Coal worker's lung, Asbestosis, Silicosis, and Berylliosis;
(d) Nervous system diseases;
(e) Blood borne infectious, contagious diseases.

(3) Within ten days after notice or knowledge of a claim for benefits, including medical benefits only, that is denied for any reason.

Pursuant to Section 8-43-103, C.R.S. (2001), "Notice of an injury, for which compensation and benefits are payable, shall be given by the employer to the division and insurance carrier, unless the employer is self-insured, within ten days after the injury . . . ."

There is no credible and persuasive evidence that this claim was denied by Respondents requiring compliance with W.C.R.P. 5-2(B)(3). In fact, Respondents filed a general admission of liability dated May 24, 2007 with the Division on July 13, 2007. Additionally, Claimant failed to prove that prior to February 4, 2007 when Employer completed the First Report of Injury, that she had filed a claim for compensation and benefits. Claimant's claim for compensation and benefits was filed on July 18, 2007. Claimant failed to prove that prior to February 4, 2007, she had missed three or more days/shifts from work as a result of her injury. Finally, Claimant failed to file her claim for penalties within one year after the date that she first knew or reasonably should have known the facts giving rise to this potential penalty. Section 8-43-304(5), C.R.S. Claimant hired an attorney to represent her by October 2007 and filed a number of applications for hearing after that date but did not list violation of W.C.R.P. 5-2(B)(3) until May 7, 2009.

TTD FROM 6/28/08 THROUGH 11/20/08

To prove entitlement to TTD benefits, claimant must prove that the industrial injury caused a disability lasting more than three work shifts, that he left work as a result of the disability, and that the disability resulted in an actual wage loss. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995); *City of Colorado Springs v. Industrial Claim Appeals Office,* 954 P.2d 637 (Colo. App. 1997). Section 8-42-103(1)(a), C.R.S., requires the claimant to establish a causal connection between a work-related injury and a subsequent wage loss in order to obtain TTD benefits. *PDM Molding, Inc. v. Stanberg, supra*. The term disability, connotes two elements: (1) Medical incapacity evidenced by loss or restriction of bodily function; and (2) Impairment of wage earning capacity as demonstrated by claimant's inability to resume his prior work. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999). The impairment of earning capacity element of disability may be evidenced by a complete inability to work, or by restrictions which impair the claimant's ability effectively and properly to perform his regular employment. *Ortiz v.*

Charles J. Murphy & Co., 964 P.2d 595 (Colo. App. 1998). TTD benefits ordinarily continue until one of the occurrences listed in § 8-42-105(3), C.R.S.; *City of Colorado Springs v. Industrial Claim Appeals Office, supra*.

Claimant is seeking TTD from June 28, 2008 through November 20, 2008. Respondents admitted to TTD from June 28, 2008 through November 20, 2008 and paid part of the TTD due and owing for this time period. (See October 28, 2008 admission of liability converting the PPD to TTD). Additionally, Insurer sent Claimant a check on September 9, 2009 in the amount of $2,645.99 for "06/27/08 THRU 11/03/08 TT UNDERPAYMENT." Since Respondents admitted to TTD from June 28, 2008 through November 20, 2008, they shall pay Claimant TTD for that time period.

AVERAGE WEEKLY WAGE

Section 8-42-102(2), C.R.S., requires the ALJ to base the claimant's AWW on his earnings at the time of injury. However, under certain circumstances the ALJ may determine the claimant's AWW from earnings received on a date other than the date of injury. *Avalanche Industries, Inc. v. Clark,* 198 P.3d 589 (Colo. 2008); *Campbell v. IBM Corp.*, 867 P.2d 77 (Colo. App. 1993). Specifically, § 8-42-102(3), C.R.S., grants the ALJ discretionary authority to alter the statutory formula if for any reason it will not fairly determine the claimant's AWW. *Coates, Reid & Waldron v. Vigil*, 856 P.2d 850 (Colo. 1993). The overall objective in calculating the AWW is to arrive at a fair approximation of the claimant's wage loss and diminished earning capacity. *Campbell v. IBM Corp., supra.* Where the claimant's earnings increase periodically after the date of injury the ALJ may elect to apply § 8-42-102(3) and determine that fairness requires the AWW to be calculated based upon the claimant's earnings during a given period of disability, not the earnings on the date of the injury. *Avalanche Industries, Inc. v. Clark, supra*; *Campbell v. IBM Corp.*, *supra*.

Claimant's 2007 W-2 shows she earned $8,286.64. Claimant's date of injury is January 20, 2007 and her last day of work was March 31, 2007. Claimant's wages from Employer for pay period ending January 20, 2007 (pay period January 14, 2007 through January 20, 2007) through March 31, 2007 was $5,452.45. During the first 14 days in January 2007, prior to the admitted injury, (pay periods December 31, 2006 through January 6, 2007 and January 7, 2007 through January 13, 2007) Claimant earned $2,834.19. Therefore, Claimant's average weekly wage is $1,417.09. The maximum TTD benefit rate at the time of Claimant's injury is $719.94.

PENALTY FOR VIOLATION OF SECTION 8-42-102(2)(D), C.R.S.

Claimant requested penalties for violation of Section 8-42-102(2)(D) for misstating her average weekly wage. This section provides for the calculation of average weekly wage for an hourly employee. Section 8-42-102 provides for a number of ways that an employee's average weekly wage may be computed. Respondents admitted to an average weekly wage of $775.39. Claimant's worker's claim for compensation dated July 18, 2007 stated her average weekly wage as $775.39. Claimant has failed to show

that Respondent's calculation of her average weekly wage is unreasonable. Claimant's request for penalty is denied.

PENALTY FOR VIOLATION OF SECTION 8-43-401, C.R.S. AND W.C.R.P. 5-5(B)

W.C.R.P. 5-5 (B) provides:

"An admission filed for medical benefits only, shall include remarks outlining the basis for denial of temporary and permanent disability benefits."

W.C.R.P. 5-5 (B) is not applicable in this case. Insurer did not file a medical benefits only admission. Therefore, Claimant's request for penalties pursuant to this rule is denied and dismissed.

Claimant has requested penalties for violation of Section 8-43-401, C.R.S. and W.C.R.P. 5-5 (B) for Insurer's failure to pay TTD from June 28, 2008 through November 20, 2008 timely. Section 8-43-401, C.R.S. provides that when all appeals have been exhausted or when there have been no appeals, insurers shall pay benefits within thirty days of when any benefits are due.

At hearing on September 10, 2009, the undersigned ALJ granted Respondents' Motion for Directed Verdict on Claimant's penalty claim pursuant to Section 8-43-401, C.R.S. based on Respondents argument that Claimant failed to present any evidence that an order had been entered requiring Respondents to pay TTD from June 28, 2008 through November 20, 2008 and failed to prove that Respondents violated such order. The ALJ incorrectly assumed that this section requires that an order be entered. The ALJ incorrectly granted a Directed Verdict on this issue. That Directed Verdict is hereby reversed.

Claimant's request for penalties pursuant to Section 8-43-401, C.R.S. shall be set for additional hearing. Since a Directed Verdict was erroneously granted, Respondents were not provided an opportunity to present evidence on this issue. Therefore, this matter shall be set for additional evidence concerning this penalty claim.

Attorney's fees against Claimant under Section 8-43-211(2)(d), C.R.S. for Claimant's endorsement of alleged violations of Section 8-43-401, C.R.S. and W.C.R.P. 5-5(B) that were not ripe

1. Respondents' request for attorney's fees against Claimant under Section 8-43-211(2)(D), C.R.S. for Claimant's endorsement of violations of W.C.R.P. 5-5(B) under ripeness grounds is denied and dismissed.

Ripeness refers to a disputed issue concerning which there is no legal impediment to immediate adjudication. *Olivas-Soto v. Genesis Consolidated Services,* W.C. No. 4-518-876 (November 2, 2005). Respondents' argument goes to whether Claim-

ant's issue is meritorious and not whether the issue was ripe for determination. "[A]n issue that lacks merit does not necessarily lack ripeness. The two concepts are distinct and a frivolous or meritless claim may nonetheless be ripe for adjudication. . . The claimant is not required to determine the likelihood that a particular defense will be successful in assessing whether an issue is ripe. As noted, that assessment is relevant to the question of merit, but not to the question of ripeness." *Younger v. Merritt Equipment Company,* W.C. No. 4-326-355 (December 30, 2009).

2. Respondents' request for attorney's fees against Claimant under Section 8-43-211(2)(D), C.R.S. for Claimant's endorsement of violations of Section 8-43-401 C.R.S. is premature (not ripe) at this time. Claimant's request for penalties pursuant to Section 8-43-401, C.R.S. has been ordered to be set for additional hearing. Until that issue has been decided, it is premature to rule on whether attorney's fees should be assessed against Claimant for list that issue for hearing.

Penalty against Claimant for violation of Section 8-43-304(1) for failing to plead penalties under Section 8-43-401, C.R.S. with specificity

Respondents' request for penalties against Claimant for violation of Section 8-43-304(1), C.R.S. for failing to plead penalties under Section 8-43-401, C.R.S. with specificity is denied and dismissed. Claimant's May 7, 2009 Amended Application for Hearing specifically states under 4. "Penalties Violation of 8-43-401 for failure to pay benefits from 6-26-08 thru 11-15-08." Claimant pled the penalty issue with sufficient specificity to put Respondents on notice of the issue. Additionally, Respondent and Claimant attended a pre-hearing conference on July 29, 2009 with Pre-hearing Judge Thomas O. McBride wherein the issues set on Claimant's application for hearing were discussed. Judge McBride set forth in his Pre-hearing Conference Order dated July 29, 2009, "The issues for consideration were respondents' and claimant's request to clarify hearing issues and consideration of issues endorsed by claimant in document entitled Amended Application for Hearing and claimant's Motion to Compel." After reviewing Claimant's May 7, 2009 Amended Application for Hearing, Judge McBride ordered that the issues set for hearing included Claimant's request for penalties against Respondents for alleged violation of Section 8-43-401, C.R.S. Respondents had more than sufficient notice and specific grounds for Claimant's request for penalties under Section 8-43-401, C.R.S.

ORDER

It is therefore ordered that:

1. Therefore, Insurer shall pay a penalty equal to one day's compensation for 30 days or $102.84 per day for 30 days, which equals $3,085.44. Fifty percent (50%) or $1,542.72 is payable to Claimant and Fifty percent (50%) or $1,542.72 is payable to the Subsequent Injury Fund.

2. Claimant's average weekly wage is $1,417.09. The maximum TTD benefit rate at the time of Claimant's injury is $719.94.

3. Insurer shall pay Claimant TTD from June 28, 2008 through November 20, 2008 at the TTD rate of $719.94.

4. Insurer shall pay interest to Claimant at the rate of 8% per annum on all amounts of compensation not paid when due.

5. Claimant's request for penalties against Respondents for failing to timely pay TTD from June 28, 2008 through November 20, 2008 pursuant to Section 8-43-401, C.R.S. shall be set for additional hearing. Respondents' request for attorney's fees against Claimant under Section 8-43-211(2)(D), C.R.S. for Claimant's endorsement of violations of Section 8-43-401 C.R.S. shall be set for additional hearing. Claimant's issue number 6 as set forth more fully in her July 29, 2009 Amended Application for Hearing shall be set for additional hearing. Respondents shall contact the Office of Administrative Courts within 10 days from the date of this order to set this matter for hearing on these issues before the undersigned Judge.

6. All matters not determined herein are reserved for future determination.

DATED: January 27, 2010

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-793-307 & WC 4-794-075

ISSUES

The issues determined herein are compensability of an occupational disease to the bilateral hands in W.C. No. 4-793-307, authorized medical benefits, average weekly wage, and temporary total disability ("TTD") benefits. Respondents admitted that claimant sustained an accidental injury to his right foot in W.C. 4-794-075.

FINDINGS OF FACT

1. Approximately ten years ago, claimant suffered bilateral hand numbness and was treated conservatively with splints and a possible cortisone injection. His symptoms resolved and he was able to work for ten years as a mortgage broker using a computer.

2. On March 18, 2009, claimant began work for the employer in Steamboat Springs as a journeyman sheetmetal worker, designing, building, and installing heating, ventilation, and air conditioning ("HVAC") systems.

3. Claimant earned $720 per week in base wages from the employer and also received $320 per week in room and board subsistence payments. The employer's "statement of weekly wages" lists claimant's actual base wages and other payments for his pay periods from March 18 through April 29, 2009. The statement then estimates additional wages for a "typical employee" because the form requested 13 weeks of wage information. The best evidence is that claimant received a total average weekly wage of $1,040.

4. Claimant's work for the employer required him to use hand tools, including rotohammering overhead into concrete, using tin snips with considerable force on his hands, and using a sawzall on 2x4 lumber set in concrete. Claimant was exposed to vibration and forceful gripping with his bilateral hands.

5. On March 27, 2009, claimant used a sawzall and began to experience bilateral hand numbness and tingling. He did not report his work injury at that time and continued to perform his usual job duties.

6. On March 30, 2009, claimant suffered an accidental injury to his right foot when he dropped the handle of a 200-pound jack and it fell onto the dorsal aspect of his right foot. Claimant finished his shift, but was unable to return to work the following day due to his right foot injury.

7. On April 1, 2009, claimant returned to work, but suffered right foot pain. He reported his injury, but was not referred for medical care.

8. On April 2, 2009, claimant chose to be treated by Dr. Sarin. Claimant reported the history of the March 30 foot injury and the March 27 onset of hand symptoms. Dr. Sarin obtained x-rays of the right foot, which were read as negative for fractures. Dr. Sarin diagnosed bilateral carpal tunnel syndrome ("CTS") and right foot contusion. He concluded that both conditions were due to work injuries. He instructed claimant to bear weight as tolerated and referred claimant to Dr. Tobey for an electromyography and nerve conduction study ("EMG").

9. On April 2, 2009, Dr. Tobey performed EMG testing, which showed mild right CTS and borderline left CTS. Claimant reported the history of the previous CTS ten years ago with treatment with splints. Dr. Tobey recommended wrist splints, increased ibuprofen, and possible injections.

10. Claimant returned to his residence in Colorado Springs. On April 5, 2009, claimant sought care at Memorial Hospital emergency room, reporting that he had the right foot injury and continued pain. X-rays of the right foot were read as normal, although claimant could have a possible microscopic fracture. Claimant was instructed to use the foot as long as he was comfortable.

11. The injections completely resolved claimant's CTS symptoms.

12. Claimant returned to his regular duty work for the employer in Steamboat Springs.

13. On April 7, 2009, Dr. Sarin reexamined claimant and administered injections in claimant's bilateral wrists. He noted that the right foot x-rays showed only diffuse degeneration, but no acute fractures. Dr. Sarin instructed claimant to return for additional treatment as needed.

14. On April 24, 2009, the employer terminated claimant's employment for allegedly poor quality and slow performance of work. Claimant testified that the termination was on May 1, 2009. That date conflicts with the employer's termination form and with the payroll records that show that claimant only worked through the pay date ending April 29, 2009.

15. Claimant returned to Colorado Springs. The record evidence does not indicate that claimant made any request for referral to a physician in Colorado Springs or that he be allowed to change to a physician of his choosing.

16. On May 4, 2009, claimant sought treatment from Dr. Malabre for his March 30 right foot injury. Dr. Malabre referred claimant to Dr. Hainge, a podiatrist.

17. On May 6, 2009, Dr. Hainge examined claimant, who reported the history of the foot injury. Claimant reported that he suffered increased foot pain after an hour of weight-bearing activity. Dr. Hainge obtained x-rays, which showed a mildly displaced third proximal phalangeal anatomical neck transverse fracture and an avulsion or chip fracture of the medial fifth proximal phalangeal head. Dr. Hainge also noted multiple areas of suspected nondisplaced hairline fractures, including at the surgical fifth metatarsal neck, lateral three proximal phalangeal base, and fourth proximal phalangeal anatomical neck regions. Dr. Hainge recommended well-supported shoes and to return to the office as needed. Dr. Hainge imposed no work restrictions.

18. On June 19, 2009, Dr. Hainge reexamined claimant, who reported only slow progress. Dr. Hainge prescribed Feldene and showed claimant samples of prefabricated orthoses for his consideration. Dr. Hainge again imposed no work restrictions.

19. On July 20, 2009, Dr. Hainge again examined claimant, who reported continued pain that was increased by an hour and a half of weight-bearing activity. Dr. Hainge diagnosed right deep peroneal and intermediate dorsocutaneous neuritis with well-healed third proximal phalangeal fracture. He again recommended use of orthotics and released claimant to perform sedentary duties and to escalate to light duty.

20. On approximately September 1, 2009, claimant began work as a part-time pizza deliverer, working 10-20 hours per week.

21. On September 17, 2009, Dr. Steinmetz performed an independent medical examination ("IME") for respondents. Claimant reported the history of the March 27 CTS and the March 30 right foot injury. He denied any previous arm symptoms. Claimant reported that his CTS had resolved after the April 7 injections, but had returned approximately three weeks ago. Claimant noted that driving worsened his arm symptoms. He also reported that he had to stop using his home computer on one occasion because of his increased CTS symptoms. Dr. Steinmetz diagnosed bilateral CTS and right foot contusion. He concluded that the CTS was not likely due to work because claimant had worked for the employer for a very short period of time. Nevertheless, he noted that claimant had a previous CTS problem 10 years ago and that he was susceptible to CTS.

22. On September 17, 2009, Dr. Zyzda, a podiatrist, also examined claimant. He noted that x-rays showed no sign of fracture and no signs of old fractures. Dr. Zyzda doubted that claimant sustained any fractures in the work injury because the jack struck the dorsal mid foot and Dr. Hainge was noting fractures of the digits. Dr. Zyzda noted no pathology that would prevent claimant from being active. He recommended a bone scan to rule out arthritic or bone contusion as well as an EMG.

23. Dr. Steinmetz then recommended a bone scan of the right foot and an EMG of the right leg. He recommended no work restrictions.

24. On September 21, 2009, Dr. Hainge reexamined claimant, who reported worsened right foot pain and the onset of right leg cramping in the calf and thigh. Dr. Hainge reviewed x-rays taken on September 16, 2009, and noted excellent alignment and healing of the third proximal phalangeal neck and the medial fifth proximal phalangeal head fractures. Dr. Hainge was unable to explain claimant's residual pain and recommended a magnetic resonance image ("MRI").

25. On September 24, 2009, claimant underwent an MRI of the right foot at Penrad Imaging and paid for the procedure out-of-pocket. Dr. Jensen reported that the MRI showed moderate soft tissue edema and degenerative changes at the first metatarsophalangeal joint. On October 1, 2009, Dr. Bergeson read the MRI as also showing a nondisplaced fracture of the third proximal phalanx.

26. On September 28, 2009, Dr. Hainge reexamined claimant and the MRI report. Dr. Hainge noted that the only conceivable diagnosis was dorsal cutaneous nerve injury secondary to a crush mechanism. He recommended referral to a pain management specialist.

27. On December 8, 2009, Dr. Hainge reexamined claimant and reviewed CD copies of x-rays from April 2 and April 5, 2009. Dr. Hainge was of the opinion that both sets of x-rays showed a compression type of transverse subcapital fracture at the third anatomical neck region and a chip fracture at the medial fifth proximal phalangeal head, but he could not determine if that was an acute or old injury. Dr. Hainge concluded that the fracture could not be the current cause of his chronic foot pain. He had no treatment to recommend other than referral to a pain management specialist.

28. Dr. Steinmetz testified at hearing consistent with his report. He noted that the brief history of work with no vibration made it unlikely that the CTS was due to work, but he admitted that it was possible that claimant suffered a temporary aggravation of his preexisting CTS. He thought that the CTS symptoms completely resolved with the injections, only to recur due to pizza delivery work and home computer use. Dr. Steinmetz thought that the work injury to the right foot involved only a contusion, which was resolved. He admitted that he had not reviewed the MRI report.

29. Claimant suffered the admitted accidental injury to his right foot in WC 4-794-075. The medical evidence is conflicting about whether it caused any fractures. In any event, those fractures, if they resulted from the work injury, have healed.

30. Claimant has proven by a preponderance of the evidence that he suffered an occupational disease to his bilateral hands resulting directly from the employment or conditions under which work was performed and following as a natural incident of the work. Claimant was sensitive to CTS exposures. His work with vibrating tools and forceful gripping aggravated his condition and required treatment. The treatment by Dr. Sarin resolved the temporary aggravation.

31. Claimant was not referred to a physician for either his right foot injury or his CTS. Claimant was impliedly authorized to choose his own authorized treating physician. He chose Dr. Sarin, who actively evaluated and treated both conditions. Dr. Sarin referred claimant to Dr. Tobey, who is also authorized.

32. Claimant subsequently chose to be treated by Dr. Malabre, but did not seek authorization to change authorized treating physicians. Dr. Malabre then referred claimant to Dr. Hainge. Dr. Hainge subsequently recommended the right foot MRI, which claimant obtained on his own. All of the treatment by Dr. Malabre, Dr. Hainge, and Penrad Imaging is unauthorized.

33. Claimant has failed to prove by a preponderance of the evidence that he was temporarily totally disabled commencing May 2, 2009, due to his right foot injury. He had returned to full-time, regular duty work for the employer until he was terminated on April 24, 2009. He had no restrictions against working his regular duty job due to the foot injury. Even Dr. Hainge did not impose any work restrictions, but merely made orthotic device suggestions to claimant, at least until the July 20, 2009, note regarding returning to sedentary and then light duty. Dr. Hainge did not explain this note. All of the other record medical evidence indicates that claimant had no work restrictions. He apparently suffered right foot pain, but it did not totally disable him.

CONCLUSIONS OF LAW

1. Claimant must prove that he is a covered employee who suffered an injury arising out of and in the course of employment. Section 8-41-301(1), C.R.S.; *see, Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844 (Colo. App. 2000); *City of Boul-*

der v. Streeb, 706 P.2d 786 (Colo. 1985); *Pacesetter Corp. v. Collett*, 33 P.3d 1230 (Colo.App. 2001). If an industrial injury aggravates, accelerates, or combines with a preexisting condition so as to produce disability and a need for treatment, the claim is compensable. *H & H Warehouse v. Vicory*, 805 P.2d 1167 (Colo. App. 1990). Claimant must prove that an injury directly and proximately caused the condition for which benefits are sought. *Wal-Mart Stores, Inc. v. Industrial Claim Appeals Office*, 989 P.2d 251 (Colo. App. 1999); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997), *cert. denied* September 15, 1997. Claimant must prove entitlement to benefits by a preponderance of the evidence. The facts in a workers' compensation case are not interpreted liberally in favor of either claimant or respondents. Section 8-43-201, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979).

2. In WC 4-793-307, claimant alleges an occupational disease to his hands. Section 8-40-201(14), C.R.S. defines "occupational disease" as:

> [A] disease which results directly from the employment or the conditions under which work was performed, which can be seen to have followed as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment, and which can be fairly traced to the employment as a proximate cause and which does not come from a hazard to which the worker would have been equally exposed outside of the employment.

This section imposes additional proof requirements beyond that required for an accidental injury. An occupational disease is an injury that results directly from the employment or conditions under which work was performed and can be seen to have followed as a natural incident of the work. Section 8-40-201(14), C.R.S.; *Climax Molybdenum Co. v. Walter*, 812 P.2d 1168 (Colo. 1991); *Campbell v. IBM Corporation*, 867 P.2d 77 (Colo. App. 1993). An accidental injury is traceable to a particular time, place and cause. *Colorado Fuel & Iron Corp. v. Industrial Commission*, 154 Colo. 240, 392 P.2d 174 (1964); *Delta Drywall v. Industrial Claim Appeals Office*, 868 P.2d 1155 (Colo. App. 1993). In contrast, an occupational disease arises not from an accident, but from a prolonged exposure occasioned by the nature of the employment. *Colorado Mental Health Institute v. Austill*, 940 P.2d 1125 (Colo. App. 1997). Under the statutory definition, the hazardous conditions of employment need not be the sole cause of the disease. A claimant is entitled to recovery if he or she demonstrates that the hazards of employment cause, intensify, or aggravate, to some reasonable degree, the disability. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). The existence of a preexisting condition does not defeat a claim for an occupational disease. Where there is no evidence that occupational exposure to a hazard is a necessary precondition to development of the disease, the claimant suffers from an occupational disease only to the extent that the occupational exposure contributed to the disability. *Anderson v. Brinkhoff*, 859 P.2d 819 (Colo. 1993). As found, claimant has proven by a preponderance of the evidence that he suffered an occupa-

tional disease of bilateral CTS resulting directly from the employment or conditions under which work was performed and following as a natural incident of the work.

3. Section 8-42-102, C.R.S. provides various methods of calculating the "average weekly wage." "Wages" is defined in section 8-40-201(19)(b), C.R.S., as:

> The term "wages" shall include the amount of the employee's cost of continuing the employer's group health insurance plan and, upon termination of the continuation, the employee's cost of conversion to a similar or lesser insurance plan, and gratuities reported to the federal internal revenue service by or for the worker for purposes of filing federal income tax returns and the reasonable value of board, rent, housing, and lodging received from the employer, the reasonable value of which shall be fixed and determined from the facts by the division in each particular case, but shall not include any similar advantage or fringe benefit not specifically enumerated in this subsection (19). If, after the injury, the employer continues to pay any advantage or fringe benefit specifically enumerated in this subsection (19), including the cost of health insurance coverage or the cost of the conversion of such health insurance coverage, such advantage or benefit shall not be included in the determination of the employee's wages so long as the employer continues to make such payment.

As found, the parties had no dispute over claimant's base wages, but disagreed over the inclusion of the value of room and board. As found, claimant earned $720 per week in base wages from the employer and also received $320 per week in room and board subsistence payments.

4. Respondents are liable for medical treatment reasonably necessary to cure or relieve the employee from the effects of the injury. Section 8-42-101, C.R.S.; *Grover v. Industrial Commission*, 759 P.2d 705 (Colo. 1988). The respondents are only liable for authorized or emergency medical treatment. See § 8-42-101(1), C.R.S.; *Pickett v. Colorado State Hospital*, 32 Colo. App. 282, 513 P.2d 228 (1973). Under § 8-43-404(5), C.R.S., the respondents are afforded the right, in the first instance, to select a physician to treat the industrial injury. Once the respondents have exercised their right to select the treating physician the claimant may not change physicians without permission from the insurer or an ALJ. *See Gianetto Oil Co. v. Industrial Claim Appeals Office*, 931 P.2d 570 (Colo. App. 1996); *Sims v. Industrial Claim Appeals Office*, 797 P.2d 777 (Colo. App. 1990). A physician may become authorized to treat the claimant as a result of a referral from a previously authorized treating physician. The referral must be made in the "normal progression of authorized treatment." *Greager v. Industrial Commission*, 701 P.2d 168 (Colo. App. 1985). If the employer fails to authorize a physician upon

claimant's report of need for treatment, claimant is impliedly authorized to choose her own authorized treating physician. *Greager, supra*. In order to change physicians, claimant has a statutory obligation to request that change in accordance with section 8-43-404(5)(a), C.R.S. *Yeck v. Industrial Claim Appeals Office*, 996 P.2d 228 (Colo. App. 1999). As found, claimant was impliedly authorized to choose Dr. Sarin. Dr. Sarin and Dr. Tobey are authorized treating physicians for both injury claims. As found, Dr. Malabre was not authorized. Consequently, Dr. Hainge and Penrad Imaging are also unauthorized to treat either work injury.

5. As found, claimant has failed to prove by a preponderance of the evidence that he was unable to return to the usual job commencing May 2, 2009, due to the effects of the right foot work injury. Consequently, claimant was not "disabled" within the meaning of section 8-42-105, C.R.S. and is not entitled to TTD benefits. *Culver v. Ace Electric*, 971 P.2d 641 (Colo. 1999); *Hendricks v. Keebler Company*, W.C. No. 4-373-392 (Industrial Claim Appeals Office, June 11, 1999). Claimant is entitled to TTD benefits if the injury caused a disability, the disability caused claimant to leave work, and claimant missed more than three regular working days. TTD benefits continue until the occurrence of one of the four terminating events specified in section 8-42-105(3), C.R.S. *PDM Molding, Inc. v. Stanberg*, 898 P.2d 542 (Colo. 1995). Because claimant is not disabled, the affirmative defense of his responsibility for termination of his employment is moot and will not be addressed in this order.

ORDER

It is therefore ordered that:

1. Claimant's claim for payment of the bills from Dr. Malabre, Dr. Hainge, and Penrad Imaging is denied and dismissed.

2. Claimant's claim for TTD benefits commencing May 2, 2009, is denied and dismissed.

3. All matters not determined herein are reserved for future determination.

DATED: January 28, 2010

Martin D. Stuber
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-782-625

ISSUES

1. Permanent partial disability benefits;
2. Causation; and
3. Apportionment.

FINDINGS OF FACT

1. On July 21, 2006, (W.C. No. 4-694-444) the Claimant who was employed by the Employer as a teacher suffered a work related injury, which included but was not limited to her neck.

2. On October 16, 2006, Dr. John Raschbacher, an authorized treating physician placed the Claimant at maximum improvement (MMI) with no impairment and no restrictions on her physical activities.

3. On October 30, 2006, Respondents filed a Final Admission of Liability in W.C. No. 4-694-444 predicated on Dr. Raschbacher's MMI opinion. Under "Permanent Partial Disability (P.P.D.)", the Respondents admitted to "NONE" under "Whole Person Impairment".

4. The Claimant objected to the Final Admission of Liability and requested a D.I.M.E. The D.I.M.E. was performed by Dr. Bennett Mechanic. Dr. Mechanic concluded the Claimant was not at M.M.I. The Respondents challenged the opinions of Dr. Mechanic. A hearing was held on the issue of M.M.I. before A.L.J. Bruce Friend on May 2, 2007. A.L.J. Friend ruled that it was "highly probable" that Dr. Mechanic's opinion concerning M.M.I. was incorrect.

5. On September 7, 2009, the Claimant returned to Dr. Mechanic for a follow-up D.I.M.E. Dr. Mechanic provided the Claimant with an 11% of the upper extremity impairment for the thoracic outlet syndrome (T.O.S.) and 10% whole person for the cervical spine.

6. The Respondents challenged Dr. Mechanic's impairment ratings. Hearings on the issue were held before A.L.J. Edwin L. Felter, Jr. on January 29, 2008 and March 18, 2008. A.L.J. Felter concluded that Dr. Mechanic's impairment ratings were incorrect and ordered "any and all claims for permanent partial disability benefits are hereby denied and dismissed".

7. On February 10, 2009, Respondents filed a Final Admission of Liability in W.C. No. 4-694-444. Under "Permanent Partial Disability (P.P.D.)," the Respondents admitted to 0% Whole Person Impairment.

8. On May 5, 2008, the Claimant was employed with the Employer as a teacher. She was supervising students playing basketball in the gym during the lunch hour. The Claimant was seated in a chair. A student who weighted approximately two hundred (200) pounds was chasing a basketball when he collided with the Claimant impacting the right side of her body, which resulted in the Claimant's head and neck snapping to the left. The Claimant experienced increased pain the next day.

9. On June 10, 2008, the Claimant was evaluated by Dr. John W. Dunkle, an authorized treating physician. Dr. Dunkle was aware of the Claimant's prior work related injuries. The Claimant indicated to Dr. Dunkle that she had developed different symptoms after her May 5, 2008 work related injury of pinching and burning in the back of her skull and lower neck with an increase in pain. Dr. Dunkle concluded these were new symptoms. Dr. Dunkle's assessment was "aggravation of cervical, thoracic, scapular and upper extremity pain". Dr. Dunkle referred the Claimant to Dr. Franklin Shih, a physiatrists, for the purpose of evaluating before and after M.R.I.'s of the Claimants cervical spine.

10. The Claimant was evaluated by Dr. Shih on June 27, 2008. The Claimant did not bring the C.D. of her most recent M.R.I. study. As a result, Dr. Shih was unable to complete the review. Dr. Shih's "assessment" was "cervical and left upper extremity pain complex, query cervical radicular complex with predominant localized neck pain".

11. On July 9, 2008, the Claimant returned to Dr. Shih. Dr. Shih compared the two (2) M.R.I.'s. Regarding the comparison, Dr. Shih opined "The 2006 MRI showed some degenerative disk changes at C5/6, as well as some uncovertebral changes. The C 6/7 levels also showed some degenerative changes. The most recent MRI shows a combination of degenerative disks and uncovertebral changes with some foraminal narrowing. I reviewed the films and felt the pathology was mild plus, although there are some areas that could be causing some of her radicular symptomatology the anatomic changes are relatively benign."

12. Dr. Shih referred the Claimant to Dr. Nicholas Olsen for a consultation regarding selective injections for interventional pain. The Claimant was evaluated by Dr. Olsen on July 23, 2008. His assessment was "cervical sprain/strain, degenerative disc discussed at C5-6 and C6-7 as noted on MRI with mild cervical spondylosis and negative EMG/nerve conduction study of left extremity." The Claimant underwent a series of injections by Dr. Olsen that provided temporary relief. On August 26, 2008, Dr. Olsen provided his final diagnosis as "Disc protrusion at C5-6 and C6-7 with left upper extremity radiculopathy and nondiagnostic left C5-6 and C6-7 facet injections."

13. On January 5, 2009, the Claimant was placed at M.M.I. by Dr. Dunkle. Dr. Dunkle conducted cervical range of motion testing on two (2) separate occasions. Dr. Dunkle utilized the best range of motion test results and concluded the Claimant had fourteen (14) percent impairment for range of motion. Dr. Dunkle utilized table 53 II C and F and concluded the Claimant had a seven (7) percent whole person rating for specific disorder. Ultimately, Dr. Dunkle did not give a range of motion impairment rating based on clinical grounds. He indicated the Claimant's range of motion testing was reliable but should not be given because the Claimant's loss of range of motion is significantly greater than what can be explained based upon cervical spine pathology. Dr. Dunkle did not provide an impairment rating for specific disorder because the Claimant had a previous work related injury with no new changes per table 53.

14. On February 10, 2009 the Respondents filed a Final Admission of Liability in W.C. No. 4-782-625 predicated on Dr. Dunkle's M.M.I. opinion. Respondents admitted to 0% permanent partial disability.

15. The Claimant objected to the Final Admission of Liability and requested a D.I.M.E. The D.I.M.E. was performed by Dr. L. Barton Goldman. Dr. Goldman indicated key areas for rating relative to the 2008 injury were soft tissue rating of the neck or chronic cervicalgia Dr. Goldman noted that the left upper extremity symptoms when they occur represent a myogenic or myfascial irritation of the brachial plexus, but not a true brachial plexopathy consistent with a normal electro-diagnostic evaluation by Dr. Shih in course of treatment for the 2008 injury. Dr. Goldman agreed with Dr. Dunkle that the Claimant was at maximum medical improvement relative to her 2008 work related injury. Dr. Goldman applied the AMA Guides third edition, revised, Chapter 3, table 53, II B and provided 4% whole person permanent impairment predicated on a diagnosis of chronic cervicalgia aggravated by the May 5, 2008 work related injury. Dr. Goldman concluded there was no objective peripheral neurologic impairment. Combining the two (2) above impairment ratings, Dr. Goldman concluded the whole person impairment rating was thirteen (13) percent whole person. Dr. Goldman apportioned ten (10) percent of his whole person rating to the prior injury. Dr. Goldman stated: "I think I have already addressed above, however, how I anticipate that this particular apportionment from a disability award perspective will very likely need to be argued based on non-medical grounds by the parties to this claim through appropriate counsel."

16. The Respondents filed an Application for Hearing dated July 29, 2009 to overcome Dr. Goldman's opinion.

17. Respondents have overcome, by clear and convincing evidence, the opinion as to permanent medical impairment from the Division IME, Dr. Goldman. Dr. Dunkle's opinion that two of Dr. Goldman's range of motions measurements fail to meet the validity criteria as set forth in the AMA Guides proves by clear and convincing evidence that Dr. Goldman's range of motion rating is incorrect. Dr. Goldman's range of motion measurements for cervical extension and left rotation do not meet the validity criteria and cannot be included in the rating. Dr. Dunkle's opinion that Claimant's range of motion rating, using the valid measurements from Dr. Goldman, is 5%. This opinion is credible and persuasive. Therefore, Claimant sustained 5% permanent impairment for range of motion deficits.

18. Respondents failed to prove by clear and convincing evidence that Dr. Goldman's 4% specific disorder of the spine rating under the AMA Guides, 3rd Edition Revised, Table 53 in incorrect. Dr. Dunkle opined that the rating should be 7% pursuant to Table 53 II C. Additionally, he opined that there were no changes on the two MRI reports taken after the prior injury on July 21, 2006 and the current injury of May 5, 2008 and therefore, no pathology due to the second injury, no new changes per table 53, and no impairment. However, Dr. Goldman diagnosed Claimant with chronic cervicalgia aggravated by the May 5, 2008 work related injury and rated Claimant under the AMA Guides Table 53 II B at 4%. Dr. Dunkle's opinion as to the rating for the specific disor-

der of the spine is a difference of opinion and does not rise to the level of clear and convincing evidence.

19. Both Dr. Goldman and Dr. Dunkle apportioned Claimant's permanent impairment to her prior July 21, 2006 injury. Dr. Dunkle apportioned Claimant's 7% impairment to her prior injury and Dr. Goldman apportioned 10% to the prior injury. As a matter of law, there is no apportionment of permanent medical impairment for the July 21, 2006 injury. In his final order dated April 4, 2008, Judge Felter found that Claimant sustained no permanent impairment as a result of the July 21, 2006 injury. Therefore, as a matter of law, there is no permanent medical impairment related to the prior injury to apportion. Pursuant to Judge Felter's Order, Claimant did not sustain any impairment to her neck as a result of the prior injury so there is no apportionment in this current claim.

20. Claimant sustained 4% permanent impairment under Table 53 for specific disorders of the spine and 5% loss of range of motion. Therefore, Claimant sustained 9% permanent medical impairment as a result of the May 5, 2008 admitted claim. Respondent shall pay Claimant permanent partial disability benefits based on 9% permanent impairment.

CONCLUSIONS OF LAW

The purpose of the Workers' Compensation Act is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), supra. Claimant shoulders the burden of proving entitlement to benefits by a preponderance of the evidence. Section 8-42-101, supra. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. Page v. Clark, 197 Colo. 306, 592 P. 2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, supra.

When determining credibility, the fact finders should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See Prudential Insurance Co. V. Cline, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, supra. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See Magnetic Engineering, Inc. v. ICAO, 5 P.3d 385 (Colo. App. 2000).

OVERCOMING DIME

PHYSICIAN ON APPORTIONMENT

Dr. Goldman, the D.I.M.E. physician opined that the Claimant had a thirteen (13) percent whole person rating for her work related injury. Dr. Goldman noted that the Claimant had a ten (10) percent pre-existing impairment rating relative to the neck provided by Dr. Mechanic, the D.I.M.E. physician in W.C. 4-694-444. Dr. Goldman apportioned ten (10) percent to the prior injury resulting in a three (3) percent rating for the most recent work related injury, in W.C. 4-782-625. Dr. Goldman anticipated the appropriateness of his apportionment would have to be determined on legal grounds.

As a matter of law, there is no apportionment of permanent medical impairment for the July 21, 2006 injury. In his final order dated April 4, 2008, Judge Felter found that Claimant sustained no permanent impairment as a result of the July 21, 2006 injury. Therefore, as a matter of law, there is no permanent medical impairment related to the prior injury to apportion. Section 8-42-104, C.R.S. (2007) (Claimant's injury occurred prior to the change in this section in July 2008) provides: "(b) When benefits are awarded pursuant to section 8-42-107, an award of benefits for an injury shall exclude any previous impairment to the same body part." Pursuant to Judge Felter's Order, Claimant did not sustain any impairment to her neck as a result of the prior injury so there is no apportionment in this current claim.

PERMANENT IMPAIRMENT RATING

Sections 8-42-107(8)(b)(III) and (c), C.R.S., provide that the determination of a DIME physician selected through the Division of Workers' Compensation shall only be overcome by clear and convincing evidence. Clear and convincing evidence is highly probable and free from serious or substantial double, and the party challenging the DIME physician's finding must produce evidence showing it highly probable the DIME physician is incorrect. *Metro Moving and Storage Co., v. Gussert*, 914 P.2d 411 (Colo. App. 1995) A fact or proposition has been proved by clear and convincing evidence if, considering all the evidence, the trier-of-fact finds it to be highly probable and free from serious of substantial doubt. *Metro Moving & Storage Co., v. Gussert*, supra. A mere difference of opinion between physicians fails to constitute error. See, *Gonzales v. Browning Ferris Indust. of Colorado*.W.C. .No. 4-350-36 (ICAO March 22, 2000). The enhanced burden of proof reflects an underlying assumption that the physician selected by an independent and unbiased tribunal will provide a more reliable medical opinion. *Qual-Med v. Industrial claim Appeals Office*, 961 P.2d 590 (Colo. App. 1998).

The DIME physician's finding under Section 8-42-107(8)(c), C.R.S., is generally the impairment rating. *DeLeon v. Whole Foods Market, Inc*., W.C. No.4-600-477 (ICAO November 16, 2006). Once a party sustains the initial burden of overcoming the DIME physician's impairment rating by clear and convincing evidence, the ALJ's determination of the correct rating is then a matter of fact based upon the lesser burden of a prepon-

derance of the evidence. *DeLeon v. Whole Foods Market, Inc., supra*. The ALJ is not required to dissect the overall impairment rating into its component parts and determine whether each part has been overcome by clear and convincing evidence. *DeLeon v. Whole Foods Market, Inc., supra*.

Claimant has proven by a preponderance of the evidence that she sustained four (4) percent permanent impairment under Table 53 for specific disorders of the spine and a five (5) percent impairment for loss of range of motion. Therefore, Claimant sustained a nine (9) percent medical impairment as a result of the May 5, 2008 admitted claim.

ORDER

It is therefore ordered that:

1. Respondents shall pay Claimant permanent partial disability benefits based on nine (9) percent permanent impairment.

2. Respondents shall pay statutory interest at the rate of eight (8) percent per annum on all amounts due and not paid when due.

3. Issues not expressly decided are reserved for future determination.

DATED: January 28, 2010

Barbara S. Henk
Administrative Law Judge

OFFICE OF ADMINISTRATIVE COURTS
STATE OF COLORADO
WORKERS' COMPENSATION NO. WC 4-793-520

ISSUES

¬ Did claimant prove by a preponderance of the evidence that she sustained an injury arising out of the course and scope of her employment?
¬ Did claimant prove by a preponderance of the evidence that surgery recommended by Dr. Erickson, an authorized treating physician, is reasonable and necessary to cure and relieve the effects of her injury?

FINDINGS OF FACT

Based upon the evidence presented at hearing, the Judge enters the following findings of fact:

22. Employer operates a retail dry goods and grocery warehouse business. Claimant has worked some three years for employer as a people greeter. Claimant contends she sustained an injury to her right knee while working for employer during the 7:00 a.m. to 4:00 p.m. shift on August 4, 2008. Claimant testified that her injury occurred near the end of her shift on August 4th when another employee pushing a line of shopping carts into the foyer struck claimant's right knee with a cart. Insurer filed a General Admission of Liability (GAL) on September 18, 2009, admitting liability for medical and temporary disability benefits.

23. Claimant reported her injury to employer on August 5, 2008, and completed a written report of injury on an "Associate Statement". Claimant answered written questions on the Associate Statement. When answering the question about the date and time of her injury, claimant indicated that she injured her right knee around 9:00 a.m. When answering how she injured herself, claimant wrote: "Pushing carts in vestible (sic)". Claimant was unable to explain why she indicated that she injured her knee at 9:00 a.m., except to say she misread the question. The above-quoted mechanism of injury reported by claimant is ambiguous and could reasonably be read as claimant stating she was pushing carts at the time she injured herself.

24. Cathie Catalano is employer's personnel manager at the store where claimant works. Ms. Catalano interviewed claimant when she filled out the Associate Statement on August 5th. According to Ms. Catalano's testimony: Claimant told Ms. Catalano that she injured her knee around 9:00 a.m. when a buggy hit her knee while moving carts. Claimant did not report to Ms. Catalano that someone else pushed the cart into her knee. Claimant did not report to Ms. Catalano that she was hit by a row of buggies. According to Ms. Catalano, claimant is a good and reliable employee.

25. Ms. Catalano typically sees claimant several times per day while claimant is working as a greeter. Ms. Catalano obtained the video surveillance of claimant's work area that was taken around 9:00 a.m. on August 4th. Crediting Ms. Catalano's testimony, the video does not show that claimant sustained an injury around 9:00 a.m. on August 4th. Ms. Catalano also saw claimant several times prior to the time Ms. Catalano left the store at the end of her shift around 3:15 p.m. Crediting her testimony, Ms. Catalano did not observe claimant in pain; indeed, claimant seemed fine. Ms. Catalano however agreed she would not know whether claimant injured herself after 3:15 p.m. on August 4th.

26. Ms. Catalano observed claimant at times using a cane before August 4th, but using one more frequently after. Ms. Catalano was unable to say which hand claimant used to hold the cane.

27. Employer referred claimant to Jeffrey E. Hawke, M.D., for an evaluation on August 5, 2008. Dr. Hawke recorded his interpretation of what claimant told him was the mechanism of injury; he wrote:

> [Claimant] was pushing carts when she turned and hit her right knee on a cart. She heard a crack and had pain. She was able to finish her shift. Last night she alternated heat and ice and lay on the couch. This morning she felt pain while sitting at work. When she got up the knee gave out, and she had to grab a wall or she would have fallen.

Claimant reported to Dr. Hawke that she had a prior injury from a fall on her right knee in 2006, for which she underwent arthroscopic surgery. On physical examination of claimant's right knee, Dr. Hawke observed swelling and a nickel-sized discoloration over the medial aspect of the patella. Dr. Hawke referred claimant for x-ray studies, which revealed a hairline fracture of the patella. Dr. Hawke diagnosed a work-related, non-displaced hairline fracture of the patella of the right knee. Dr. Hawke released claimant to return to work under physical activity restrictions.

28. Dr. Hawke eventually referred claimant to Orthopedic Surgeon Jon M. Erickson, M.D., for an evaluation on September 4, 2008. Dr. Erickson reported the following mechanism of injury on August 4, 2008:

> Condition occurred as a result of an injury while working as a greeter … when she struck her anterior knee on a shopping cart.

Dr. Erickson obtained x-ray studies that showed no abnormality of the patella of the right knee. Dr. Erickson ordered a magnetic resonance imaging (MRI) scan of claimant's right knee. On September 16, 2008, Dr. Erickson reported that the MRI revealed chronic chondromalacia of the patella and a compression fracture of the lateral tibial plateau. Dr. Erickson diagnosed a knee contusion and compression fracture, which he felt should resolve in 3 to 5 months.

29. On October 16, 2008, Dr. Erickson noted that claimant had failed to improve. Dr. Erickson recommended arthroscopic surgery, with chondroplasty and excision of a synovial cyst. Dr. Erickson reported:

> She is aware that this surgery will not have any effect on her subchondral contusion.

Dr. Erickson twice requested authorization to proceed with surgery: On October 16, 2008, and on March 5, 2009.

30. Insurer referred claimant to Orthopedic Surgeon Michael S. Hewitt, M.D., for an independent medical examination on January 21, 2009. Dr. Hewitt recorded the following history of mechanism of injury:

> [Claimant] was working as a greeter … when she was struck in the anterior aspect of her right knee from a shopping cart. She noted immediate onset of pain. She completed her shift that day but noted increasing pain and giving away the following day. Radiographs were … read as an incomplete hairline patellar fracture.

Dr. Hewitt reviewed medical records of right knee treatment claimant underwent prior to August 4, 2008, including a history of a cortisone injection into her right knee on July 31, 2008, a few days prior to her injury at employer. Dr. Hewitt opined as follows:

> [Claimant] sustained a direct blow to the anterior aspect of the right knee from a shopping cart. Initial x-rays were suspicious for an incomplete nondisplaced patellar fracture but an MRI .. does not confirm a fracture. Her work related injury of 8/04/2004 (sic) appears to have been a contu-

sion. **There may have also been an exacerbation of her long-standing underlying degenerative arthritis.**

(Emphasis added). Dr. Hewitt recommended against surgery in favor of conservative treatment, including an exercise program, bracing, cortisone injections, and visco supplementation injections.

31. Dr. Hawke referred claimant to Physiatrist Nicholas K. Olsen, D.O., for consultation on April 9, 2009. Dr. Olsen recorded the following mechanism of injury:

> On 8/4/08, [claimant] was injured when a train of carts was pushed into her right knee. She explains a co-employee was pushing a long train of carts and the building obscured this person's view. As the carts were pushed, they struck her knee resulting in a hairline fracture of the patella, according to [claimant]. Since that time, she has noticed fairly significant knee pain.

Claimant reported to Dr. Olsen her past history of medical treatment for her right knee. Dr. Olsen noted several possible pain generators in claimant's right knee, including bone marrow edema of the proximal tibia and a component of osteoarthritis. Dr. Olsen recommended a Cryo/Cuff unit, viscosupplementation to address the arthritis, and a home exercise program.

32. On May 7, 2009, Dr. Olsen administered an injection of Synvisc into the patellofemoral space. Dr. Olsen released claimant from work for a period of time. Dr. Olsen released claimant to full-duty work on May 20, 2009. By June 18, 2009, Dr. Olsen noted that conservative treatment had failed to alleviate claimant's symptoms. Dr. Olsen recommended claimant consider arthroscopic surgery recommended by Dr. Erickson.

33. Dr. Hewitt reevaluated claimant on August 7, 2009. Claimant reported no significant benefit from the Synvisc injections. Dr. Hewitt reiterated his opinion that claimant's current symptoms are not causally related to her injury at employer, given her extensive history of knee arthritis, multiple surgeries, and the fact that her injury was an anterior knee impact from a shopping cart. Dr. Hewitt further opined:

> I do feel [claimant] is approaching maximum medical improvement [MMI]. Although her symptoms do not entirely focus on her knee, she understands that the final treatment option for advanced knee arthritis … would be a total knee replacement. Given her long history of knee arthritis, predating her work related injury, I do not feel a knee replacement would be covered by an exacerbation of a pre-existing symptomatology.

Dr. Hewitt recommended an exercise program and cortisone injections to maintain claimant's condition at MMI.

34. Insurer seeks prospective relief from its GAL, contending that video surveillance of claimant working around 9:00 a.m. on August 4, 2008, fails to show she injured her right knee. In addition, the testimony of Ms. Catalano and Dr. Hewitt's review of claimant's preexisting right knee condition raise questions sufficient to question whether claimant injured her right knee at work.

35. Claimant showed it more probably true than not that she sustained an injury on August 4, 2008, arising out of the impact of a row of carts impacting her right knee. Insurer reasonably relied on what claimant reported in the Associate Statement and to Ms. Catalano and upon the video surveillance in seeking prospective relief from the GAL. Claimant's various reports concerning the mechanism of injury are inconsistent. However, claimant's testimony is otherwise sufficiently consistent with a mechanism of injury involving impact with a cart, as she initially and consistently reported to physicians involved in her claim. More importantly, claimant's testimony concerning the mechanism of injury is supported by Dr. Hawke's examination findings of acute pathology on August 4, 2008, including bruising, swelling, and radiological findings of a fracture of the patella. In addition, Dr. Erickson also found evidence that claimant sustained bone-bruising and a fracture of the tibial plateau of her right knee. These findings tend to support claimant's testimony about an acute injury from the impact of a shopping cart. The Judge thus credits claimant's testimony concerning the mechanism of her injury in finding that she proved by a preponderance of the evidence that she sustained a compensable aggravation of her preexisting right knee condition.

36. Dr. Hewitt testified as an expert in the area of Orthopedic Surgery and as a Level II accredited physician. Dr. Hewitt does not believe claimant will benefit from the arthroscopic surgery recommended by Dr. Erickson. Dr. Hewitt based his opinion upon the following: Claimant has undergone 4 prior arthroscopic surgeries that failed to alleviate her symptoms from her underlying arthritic condition in her knees. In addition, claimant's injury at employer involved the front of her knee, yet Dr. Hewitt's physical examination showed claimant complaining of diffuse tenderness. Dr. Hewitt's examination findings thus are diffuse, non-focal, and fail to describe a specific pain generator. According to Dr. Hewitt, claimant's complaints are more consistent with symptoms from her underlying degenerative joint disease, caused by her progressive arthritic disease, and inconsistent with a healed fracture of the patella. Dr. Hewitt also reasoned that a 2007 operative report revealed a bone-on-bone condition from the arthritis that likely will require a total-knee replacement as end-stage treatment of the underlying disease. Dr. Hewitt thus recommended against arthroscopic surgery because of the extent of the preexisting arthritic disease process in claimant's right knee.

37. Claimant showed it more probably true than not that arthroscopic surgery recommended by Dr. Erickson is reasonable and necessary to cure and relieve the effects of her injury. Dr. Erickson's surgical recommendation is supported by the medical opinions of treating physicians, Dr. Hawke and Dr. Olsen. Dr. Hewitt explained that the surgery recommended by Dr. Erickson likely will involve inspecting the inside of the knee joint with a camera and removing a synovial cyst, which could be the result of the trauma from impact of the shopping cart. Dr. Hewitt agreed that Dr. Erickson believes the surgery will help claimant and that reasonable surgeons can disagree on this point. Because surgeons can reasonably disagree, the Judge credits the surgical recommendation of Dr. Erickson because it is supported by the medical opinions of two treating physicians, one of whom (Dr. Olsen) is a Physiatrist. Claimant thus proved by a preponderance of the evidence that arthroscopic surgery recommended by Dr. Erickson is reasonably necessary to cure and relieve the effects of claimant's work-related aggravation of her underlying degenerative arthritis.

38. Claimant showed it more probably true than not that medical treatment provided by Dr. Hawke, Dr. Olsen, and Dr. Erickson, and from providers to whom they have referred claimant, is reasonable and necessary to cure and relieve the effects of claimant's injury.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact, the Judge draws the following conclusions of law:

Claimant argues she has proven by a preponderance of the evidence that she sustained an injury arising out of the course and scope of her employment and that surgery recommended by Dr. Erickson is reasonable and necessary to cure and relieve the effects of her injury. The Judge agrees.

The purpose of the Workers' Compensation Act of Colorado (Act), §§8-40-101, *et seq.*, C.R.S. (2009), is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. Section 8-40-102(1), *supra*. Claimant shoulders the burden of proving by a preponderance of the evidence that her injury arose out of the course and scope of her employment. Section 8-41-301(1), *supra*; *see City of Boulder v. Streeb*, 706 P.2d 786 (Colo. 1985). A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979). The facts in a workers' compensation case must be interpreted neutrally, neither in favor of the rights of claimant nor in favor of the rights of respondents. Section 8-43-201, *supra*.

When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. *See Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); CJI, Civil 3:16 (2005). A Workers' Compensation case is decided on its merits. Section 8-43-201, *supra*. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. *See Magnetic Engineering, Inc. v. ICAO,* 5 P.3d 385 (Colo. App. 2000).

Once compensability is established, respondents are liable for medical treatment that is reasonably necessary to cure and relieve the effects of the industrial injury. Section 8-42-101(1)(a), *supra*; *see Colorado Compensation Insurance Authority v. Nofio,* 886 P.2d 714 (Colo. 1994); *Snyder v. Industrial Claim Appeals Office*, 942 P.2d 1337 (Colo. App. 1997).

Here, the Judge found claimant showed it more probably true than not that she sustained an injury on August 4, 2008, arising out of the impact of a row of carts impacting her right knee. Claimant thus sustained her burden of proving by a preponderance

of the evidence that she sustained a right knee injury on August 4, 2008, and that she is entitled to benefits under the Workers' Compensation Act.

The Judge further found claimant showed it more probably true than not that arthroscopic surgery recommended by Dr. Erickson and medical treatment provided by Dr. Hawke, Dr. Olsen, and Dr. Erickson, and by providers to whom they have referred claimant, is reasonable and necessary to cure and relieve the effects of claimant's injury. Claimant thus proved entitlement to medical benefits by a preponderance of the evidence.

The Judge concludes that insurer should pay, pursuant to fee schedule, for arthroscopic surgery recommended by Dr. Erickson. The Judge further concludes that insurer should pay, pursuant to fee schedule, for medical treatment provided by Dr. Hawke, Dr. Olsen, and Dr. Erickson, and by providers to whom they have referred claimant.

ORDER

Based upon the foregoing findings of fact and conclusions of law, the Judge enters the following order:

1. The parties's request to reserve the issue of apportionment is granted.

2. Insurer shall pay, pursuant to fee schedule, for arthroscopic surgery recommended by Dr. Erickson.

3. Insurer shall pay, pursuant to fee schedule, for medical treatment provided by Dr. Hawke, Dr. Olsen, and Dr. Erickson, and by providers to whom they have referred claimant.

4. Issues not expressly decided herein are reserved to the parties for future determination.

5. If you are dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 633 17th Street, Suite 1300, Denver, Colorado, 80202. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a petition to review form at: http://www.colorado.gov/dpa/oac/forms-WC.htm.

DATED: __January 28, 2010___

Michael E. Harr,
Administrative Law Judge